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AARP	1	9	The selected plans demonstrate a proven track record of business integrity and high quality service delivery.	Unfortunately, most of the selected plans have very poor scores on patient experience measures, as reflected in the latest report of the External Quality Review Organization on the results of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys. The ratings on "Getting Needed Care" show that all but two of the plans selected have ratings of one star out of five, indicating they have "poor" performance in comparison to Medicaid plans nationwide. These plans are also below the California Medical Managed Care average rating. (Health Plan of San Mateo and CalOptima are both above average and have a two star rating.) It is also worth noting one of the selected plans in San Diego, Molina Healthcare, has a warning to consumers on the Medicare.gov website indicating that they have had low ratings for three years. The National Senior Citizens Law Center recently published a report summarizing the Medicare and Medi-Cal quality ratings of the selected plans (Assessing the Quality of California Dual Eligible Demonstration Healthy Plans, May 2011), which is not comforting.
AARP AARP	2	10	California proposes to implement the demonstration in the following ten counties: Alameda, Contra Costa, Los Angeles, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Mateo, and Santa Clara Counties. The four counties where the demonstration will be implemented under current state law are: Los Angeles, Orange, San Diego, and San Mateo Counties.	This is far too large for a demonstration. We agree that San Mateo and Orange Counties are both ready and appropriate for the demonstration, and San Diego is clearly the most ready of the geographic managed care counties. To select Los Angeles, a county the size of the State of Ohio, as a demonstration site is a huge mistake. There are other two-plan counties (e.g., Alameda) that are far more ready and of a manageable size that would be more appropriate. Furthermore, we strongly object to the expansion of the demonstration beyond the four counties, unless the purpose is to add a non-managed care area, which we believe should be included.
AARP	3	10	The State will use a unified, passive enrollment process through which dual eligible beneficiaries who do not make an affirmative choice to opt out will be automatically enrolled into a demonstration health plan.	AARP policy supports freedom of choice for all Medicare beneficiaries. Beneficiaries should be making an affirmative choice whether to enroll into a plan for receipt of their Medicare benefits. However, we are not necessarily opposed to passive enrollment in the context of the dual eligible demonstrations in which California is seeking to participate through this proposal. Our tolerance for passive enrollment, however, is dependent on the context in which it is proposed, and in the context of this particular proposal we must strenuously object. First, we have no confidence that beneficiaries will be in a position to make an informed choice. There is no choice counseling offered from independent sources to assist in making what in many cases are going to be a very complex set of choices. The proposal makes clear that some external source of funding would have to be found to pay for such an effort. It is critical that there be a system for conflict-free, independent enrollment counseling with clearly identified adequate, stable funding. Furthermore, the experience in the recent transition of non-dual seniors and persons with disability gives us no comfort that the state has any idea how to effectively communicate with this population. While the state finally seems to understand there was a problem, they seem at a loss as to how to effectively address it. The context also includes a proposed "lock-in" of six months, which AARP strongly opposes. Finally, the state has opted to contract with plans with poor patient experience measures, as indicated above. In this context, we cannot support passive enrollment.
AARP AARP	4	10	Enrollment will be implemented on a phased-in basis throughout 2013.	The state will not be ready to implement this demonstration in a responsible manner starting in 2013. This document indicates that many key tasks have not been completed, including such basics as developing LTSS network adequacy standards, care coordination standards and grievance and appeal procedures. This document is replete with references to
AARP	5	10	The State is proposing a passive enrollment process with a stable enrollment period to ensure a sufficient volume of enrollees over the demonstration period.	The proposal for a lock-in period (called a stable enrollment period in this document) is just one of many indications that the state is not ready to implement this demonstration and explain the benefits of participation to beneficiaries. The state clearly sees a need to force vulnerable people with complex care needs to stay in plans during what they must contemplate will be a very difficult and confusing period. Beneficiaries should always have the ability to change plans or opt out into Original Medicare. It is not only good for them, it is really the only early warning sign that the state will receive that there are issues that beneficiaries are unable to resolve within the plan. Instead of resorting to such drastic measures, the implementation of the demonstration should be delayed until all the basic issues can be resolved so plans, providers and consumers all can know what is involved if they participate.
AARP			Medi-Cal and Medicare medical necessity standards will not be restricted by health	This seems to be backwards. Did you mean that health plans will not be restricted by Medi-Cal and Medicare medical necessity standards?

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AARP	6	13	plans, ensuring that individuals have access to any benefits they would have had access to absent the demonstration.	
AARP	7	1300%	Care coordination standards. New standards will be developed in collaboration with public stakeholders.	This is fundamental to the administration of these demonstrations. While it is encouraging the state wants stakeholders involved, this demonstration cannot go forward until care coordination standards are developed, communicated clearly to plans and other stakeholders, and the standards are operationalized by developing processes and training the staff responsible. If the state is at this late date saying that the standards are to be developed in the future, there is no way this
AARP				
AARP	8	13	Demonstration plans will be responsible for an in-depth risk assessment process capable of timely identification of primary, acute, LTSS and behavioral health needs.	The assessment is another fundamental component of these demonstrations. In this case, the state is simply asserting that plans will be responsible for doing one that assesses the medical, behavioral health and LTSS needs. Later in the document the state suggests a uniform assessment of LTSS needs will be developed over a three year period. While we appreciate the general direction of requiring a comprehensive assessment, including the preferences of the beneficiary, we are concerned about the lack of direction as to how the assessment will be done, particularly for the LTSS services with which most of the selected plans have no experience. Again, this is something that needs to be clarified, and
AARP				
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AARP	9	14	Building on lessons from the transition of seniors and persons with disabilities into Medi-Cal managed care, the State will work with plans and providers to ensure necessary processes and procedures are in place to support timely health risk assessments. In addition, California's health plans will use promising practices, such as repeated attempts to gather assessment information, via various modes (phone, mail, interactive voice by phone), web-based care planning tools that allow providers and beneficiaries to view and add to the care plan, etc.	This is not comforting. It is not at all clear that the state has learned lessons from the transition of seniors and persons with disabilities into Medi-Cal managed care. Only recently has the state seemed to recognize there were serious issues, primarily around the failure to effectively communicate with providers and beneficiaries, but there is no indication the state has yet developed an effective approach to address these critical issues. The reference here to calls, mail, and web based tools is unnerving given the information that recently came out from the California Health Care Foundation about the need for more high-touch approaches. Once again, the state is essentially saying that they will figure it out in the future. With enrollment fast approaching, that is not good enough.
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AARP	10	14	Health plans are encouraged to provide an active role for members in designing their care plans.	Encouragement is not good enough, particularly when it comes to LTSS services. LTSS can be provided in a variety of settings and the preferences of the beneficiary should govern the setting in which they will be provided. Plans should be held to a very exacting standard when it comes to involving beneficiaries in the development of care plans.
AARP				
AARP	11	17-18	Starting in June 2013, the State will lead a stakeholder process to develop a statewide HCBS Universal Assessment Process. This process shall be implemented no earlier than January 1, 2015. Providers, counties, and managed care plans will use it to assess the need for home- and community-based services. ..As noted above, this tool will be separate from and will not replace the Health Risk	First, it is not clear what the relationship between the assessment plans are to do on page 14, which appears to include all medical, behavioral and LTSS needs, and this assessment. On its face, this would seem to replace a subset of the LTSS assessments, those dealing with home and community based services but not nursing facility services. Since one of the clear goals of the demonstration is to promote the use of HCBS in lieu of nursing facilities, it does not seem to make sense to separate the assessments. Indeed, a person who is eligible for either nursing facility services or HCBS should have the choice of the setting they prefer. This seems to set up a two-step process with different standards that is going to be confusing to beneficiaries, their families, and the entire LTSS community.
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Organization	Comment #	Page # of Proposal	Relevant Language	Proposal Draft Language & Comment
AARP			Assessment process used by managed care plans when beneficiaries initially enroll.	
AARP	12	18	In 2015, California may also implement the Managed Fee-for-Service (FFS) model for this demonstration, using the guidelines provided by CMS.	AARP supports the development of a fee-for-service model, and would support statutory authority to add additional counties where this model could be demonstrated.
AARP	13	18	Participating health plans will apply evidence-based clinical guidelines promulgated by leading academic and national clinical organizations. Plans will be required to have processes for educating providers on employing evidence-based guidelines and for monitoring providers' use of evidence-based practices.	This could be a very complex and controversial provision, depending on what standards are used and how it is implemented. It appears that the state is delegating to plans the decision as to which standards to use, and is expecting plans to deny treatment or services that the plans do not believe is consistent with the standards. This has the potential to be extremely confusing and disruptive and lead to disparities in access and quality. If new standards for treatment are imposed, they ought to be uniform as to all plans and developed in a public process where providers and consumers, as well as plans, can offer their views.
AARP				
AARP	14	18	California's Section 1115 "Bridge to Reform" waiver provides a strong foundation for integrated care service delivery for high-need, complex populations.	We disagree for the reasons stated in comment #9. Also, the non-COHS plans that just recently enrolled non-dual seniors and persons with disability are just starting to deal with this population. Their major experience has been with young families and with the enrollment process for non-dual seniors and persons with disabilities. Delaying the implementation date as suggested in comment #4 will give the plans more relevant experience with a more similar, if less vulnerable population.
AARP	15	20	The State is considering options for how new enrollment in these waivers would be treated under the demonstration, and welcomes stakeholder feedback on this issue.	Again, it is appreciated that the state is seeking stakeholder input on this issue at this point, but how the existing waivers are incorporated into the demonstration beyond existing slots is a question many stakeholder have been asking the state for some time. Our impression has been that this is an issue that is under discussion with CMS and we are not clear what the issues are that is preventing the state from advancing a proposal in this regard. It seems to us that if there are limited slots in the waivers, someone is going to have to administer a process to authorize additional requests for services, presumably the state. It seems clear that plans could opt to provide the waiver services with the funds they receive from the state in
AARP				
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AARP	16	21	By the second year of the demonstration, MSSP and managed care plans' care management will be fully integrated. By the third year of the Demonstration, MSSP will cease to exist as a separate, independent program from the plans' care management operation.	We think this is a serious mistake. The MSSP program has a long history of successfully providing intense case management services for nursing facility eligible persons so they can remain in the community. This is an infrastructure that should be preserved and built on, not destroyed in favor of a system administered by plans which have never done this type of work. The better model would be to require plans to contract with MSSP for case management of these high need individuals who are nursing facility eligible and express a preference for living in the community.
AARP				
AARP	17	21	Plans' Model of Care will include eligibility, protocols and guidelines on utilizing CBAS as a substitute for nursing facility care. Plans' care management teams will authorize CBAS services and coordinate CBAS in relation to medical services and other LTSS needed by the beneficiaries.	This description does not appear to contemplate the central role of beneficiary preference we believe should be determinative in the decision as to what type of LTSS services should be authorized for persons who are eligible for nursing facility care. LTSS is fundamentally different than medical care; it about how a person is going to live their life, not about a diagnosis and prescription by an expert. We worry not just about access to home and community based services, like CBAS, but access to nursing facilities as well. In a managed care environment the more expensive options may well become harder to get authorized. It should be the choice of the individual, pure and simple.
AARP				
AARP			Upon completion of these	Again, these decisions need to be made well prior to implementation. Also, it is not at all clear from this proposal what the

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AARP	18	22	activities, the State is considering whether waiver programs would cease to take on new beneficiaries and all waivered services and care coordination would be undertaken by the demonstration plans. In Demonstration counties, the waiver programs would continue to operate until the end of the waiver periods for existing waiver recipients.	status of these waiver programs would be outside of the demonstration counties.
AARP				
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AARP	19	25	Contingent upon available private or public dollars other than moneys from the General Fund, contract with community-based, nonprofit consumer or health insurance assistance organizations with expertise and experience in assisting dual eligible beneficiaries in understanding their health care coverage options.	This demonstration should not go forward unless and until a stable, ongoing source of funding is identified and dedicated to providing independent choice counseling for dual eligible beneficiary who will be required to make some very complex decisions concerning whether to participate in the demonstration.
AARP				
AARP	20	26	Health-Risk Assessment. This is an essential consumer protection; the State will require that managed care health plans perform an assessment process that: • Assesses each new enrollee's risk level and needs, based on an interactive process such as telephonic, web-based, or in-person communication with the beneficiary. • Addresses the care needs of the beneficiary and coordinates their Medicare and Medi-Cal benefits across all settings. • Reviews historical Medi-Cal and Medicare utilization data. • Follows timeframes for reassessment.	This assessment needs to incorporate the preferences of the beneficiary, including preferences for the setting in which LTSS are to be provided. Where there is any indication of the need for LTSS, this needs to be done in person.
AARP				
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AARP	21	26	Plans will be required to establish and maintain provider networks that at least meet Medi-Cal access standards for long-term services and supports (currently under development by the State),…	The demonstration clearly cannot go forward until these standards are developed, communicated to plans and other stakeholder, and operationalized through contracts or other processes. Another reason to delay the implementation as suggested in comment #4.
AARP				

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AARP	22	27	The State will work with CMS and stakeholders to develop a unified state and federal grievance and appeals process for beneficiaries enrolled in the demonstration.	This is another fundamental issue that has not yet been addressed at this late date. Another reason to delay the implementation as suggested in comment #4. This is an area where the design is particularly important ensure that this vulnerable population has a real, effective opportunity to develop and present their case, which in some cases will mean access to a professional advocate with the requisite legal and medical expertise, as well as access to independent medical assessments. A robust consumer education component so that beneficiaries know their rights is an integral component as well.
AARP	23	28	CMS indicates it will require a performance based withhold of 1%, 2%, and 3% respectively for years one, two and three of the demonstration. The State is also considering quality incentives, in addition to the CMS required withholds.	AARP strongly recommends that quality incentives include performance on patient experience (i.e., CAHPS scores) since most of the plans selected are so poor in this area.
AARP	24	31	The State will use a combination of existing resources and additional infrastructure to implement this demonstration.	The state has severe capacity issues that is adversely impacting the ability to effectively design and, we are afraid, oversee this demonstration. We are uncomfortable having this demonstration move forward until the state is able to address the key design issues sufficiently in advance of implementation so all stakeholders know what is being proposed, and what role the various state agencies, the EQRO, consumers and others will have in overseeing and evaluating the demonstration. The severe, ongoing budget crisis in this state is driving premature implementation of this proposal for the wrong reasons and is hindering the development of capacity required to make this demonstration successful. It is clear from this document that the state is resource constrained and is unwilling or unable to invest necessary resources, the most blatant example being the express unwillingness to invest in choice counseling for beneficiaries.
AARP	25	31	CDA may expand HICAP counselors for the 2012 Open Enrollment period for the Demonstration counties.	This is an unrealistic suggestion at this point in time. Open enrollment starts in October. The open issues will not be resolved in time to train HICAP counselors for the 2012 open enrollment period, and at this late date HICAP is not going to be able to recruit and train sufficient counselors in the four selected counties. Counselors will need to be adept at explaining not just Medicare options, but Medi-Cal as well. This may be a realistic suggestion for the 2013 open enrollment period, but not for this year.
AARP	26	32	In conjunction with the passive enrollment process, the State is seeking federal approval to establish a six-month minimum stable enrollment period for beneficiaries who enroll in the demonstration.	AARP strongly opposes the lock-in period, as indicated in comment #5.
AARP	27	32	The State anticipates that there may be a need for flexibility around current Medicaid rules and requirements in order to align the enrollment process with Medicare, as well as flexibility related to actuarial soundness if required for the blended payment rate.	It is not clear what is being proposed in this regard. Flexibility regarding the requirements for actuarial soundness is very concerning given the state's fiscal condition. AARP has been very vocal about the unrealistic budget savings estimates advanced in the state budget process and what that may mean for beneficiaries if the demonstrations are inadequately funded. The benefits and services to which beneficiaries are entitled needs to be crystal clear and the funding needs to adequate to provide those benefits and services. The failure of the state to clearly set forth the flexibilities and changes to Medicaid rules that the state needs to implement this demonstration makes it impossible for consumers and other stakeholders to meaningfully comment.
AARP			The Governor's Coordinated Care Initiative proposes to expand the demonstration as follows: • 2013: Up to ten counties with Medi-Cal managed care. • 2014: All remaining counties that currently have Medi-Cal managed care.	AARP opposes this rapid expansion. The state will not be ready to responsibly implement the demonstration in the four counties currently authorized in 2013. It should not be expanded until the four county demonstrations are successfully implemented and robustly evaluated. It is imperative that the state take a cautious approach to putting vulnerable older adults and persons with disabilities into risk-based managed care plans. The proposed capitated financing arrangement for medical services and LTSS will change incentives, undoubtedly in ways that cannot all be anticipated, particularly with most managed care plans having no experience in administering LTSS. These demonstrations need to be subjected to careful evaluation prior to an expansion as proposed in this document.
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AARP	28	33	• 2015: All remaining counties, including the 28 current Medi-Cal fee-for-service counties. These counties will transition to Medi-Cal managed care beginning in June 2013. The State may also implement the demonstration using the Managed Fee-for-Service model in counties without Medi-Cal managed care.	
AARP				
AARP	29	34	Note also that the Coordinated Care Initiative provides that if the California Department of Finance determines, annually on September 1, that the Initiative has caused utilization changes that result in higher State costs than would have occurred absent the Initiative, after fully offsetting implementation administrative costs, then the State will discontinue the provisions of the Initiative.	This is notable because of the lack of confidence it indicates the state itself has in the fiscal estimates it has advanced. It makes no sense to implement a large scale change as the state has proposed and then discontinue it because the estimates were inaccurate. It indicates more than anything the need for a smaller, more fleshed out demonstration proposal than is being advanced by the state in this document.
AARP	30	35	It is anticipated that LTSS network adequacy measures will be established during the three-year demonstration.	This is something that needs to be done before the commencement of the demonstration, not by the time it is over.
AARP	31	35-6	Although current state law provides authority to implement the demonstration in up to four counties, the Governor's Coordinated Care Initiative seeks Legislative authority to implement the following aspects of the demonstration: • Implement the demonstration in up to 10 counties in 2013, additional counties in 2014, and statewide by 2015. • Maintain beneficiary enrollment for the first six months after initial enrollment.	As previously indicated, AARP opposes these proposals.
AARP				
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Alzeimer's Association of Southern California	1	2	This information will be delivered in a format and languale accessible to enrollees	How will the state assure that cognitively impaired people get this information as described?. An estimated 20% live alone.

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Alzeimer's Association of Southern California	2	9	Person-Centered Care Coordination	Will the individual health risk assessments include assessment for cognitive impairment? This is critical or the care plan will be meaningless
Alzeimer's Association of Southern California	3	10	Passive enrollment process	A passive enrollment process is of concern to people with dementia, especially if they live alone. Unless accommodations are made to assure continuity of care, this is going to cause disrupted care and could result in negative outcomes .
Alzeimer's Association of Southern California	4	11	Provider Networks	People with Alzheimer's may need specialty care from Geriatric Psychiatrists/ With the mental health carve out, Counties provide behavioral health care. They do NOT serve people with Alzheimer's even when these peopl have mental health issues.
Alzeimer's Association of Southern California	5	11 &26	Provider Networks	We need to assure that the network includes neurologists or geriatricians with dementia expertise.
Alzeimer's Association of Southern California	6	12	Supplemental Benefits	Unfortunately, many providers of IHHS, CBAS and MSSP also need training in dementia care. These services will only reduce hospitalization and institutionalization if these providers are dementia capable
Alzeimer's Association of Southern California	7	15	Upon receipt of the referral, care managers conduct a comprehensive assessment, …. Are the care managers going to be trained in dementia care management? This involves unique skills and training and can be very cost-effective . Two studies show this type of training can cut the use of costly hospitalization, and ER use while improving quality of care.	
Alzeimer's Association of Southern California				
Alzeimer's Association of Southern California	8	16	Use of technology	Fewer than 20% of people with Alzheimer's disease have it coded in their medical records. For technolgy to be effective, assessments and diagnostic work-ups will need to be completed.
Alzeimer's Association of Southern California	9	17	Gov's Coord. Care Initiative would require duals to enroll in mco's for LTSS	How will the systems assure that cognitively impaired people won't lose the LTSS ? They may not understand this requirment.

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Alzeimer's Association of Southern California	10	17	New Universal Assessment Tool	How can we assure this tool takes into account the cognitively impaired person's functiional capacity including the need for prompting? Currently, some LTSS providers cannot assess the needs of this population. There is a need for training.
Alzeimer's Association of Southern California	11	18	Evidence-based Practices	We need to assure that the California Guidelines for Alzheimer's Disease Management is used by all providers to develop systems of care for people with dementia.
Alzeimer's Association of Southern California	12	21	MSSP, CBAS	The State needs to assure that these service providers are competent to serve vulnerable people with dementia. A certification program with appropriate training might be beneficial. Otherwise, dementia patients will continue to cost the state 19 more through Medicaid than other benficiaries and cost Medicare 3 X more than other beneficiaries because they will not be receiving appropriate care.
Alzeimer's Association of Southern California				
Alzeimer's Association of Southern California	13	24	Stakeholder feedback	Advocacy groups may be asked to serve on advisory committees but do they have recourse if their advice isn't followed. This could just be lip service to stakeholder engagement. Will CEO's participate or just low level staff?
Alzeimer's Association of Southern California	14	25	Self-direction of care	Accommodations must be put in place to assure that surrogate decision makers are vetted AND that they can give input on a patient's care
Alzeimer's Association of Southern California	15	25	Notificatin about Enrollment Process	"Properly informing beneficiaries (or, as appropriate, their surrogate decision-makers) about enrollment rights…" There is still going to be a problem determining which beneficiaries have cognitive impairment and need a surrogate.
Alzeimer's Association of Southern California	16	26	Health Risk Assessment	Please add: "Assesses the new enrollee's cognitive status and capacity to make informed decisions."
Alzeimer's Association of Southern California	17	28	Performance-based reimbursement	People with dementia are time-consuming. Provider reimbursement needs to be higher for these patients who may not be perceived as complex but,who are time-consuming to manage correctly.
Anthem Blue Cross	9	Care Transitions	“Broad Network Adequacy. Demonstration sites shall ensure availability of **all services** in a member’s care plan.”	Would DHCS clarify in the final proposal, that demonstration sites are to ensure availability of all **covered services** (as opposed to all services) in a member’s care plan? Anthem recognizes the importance of having comprehensive care plans and supports DHCS' efforts to ensure that care plans provide availability of covered services and, at the same time, identify carved-out services so the interdisciplinary care team is aware of all services that may be available to members.

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Anthem Blue Cross	19	Care Transitions	Enhanced outreach and education processes for beneficiaries and providers are needed, particularly around enrollment rights and the medical exemption review process in the duals demonstration to guarantee continuity of care.	Please define the medical exemption review process.
Anthem Blue Cross	14	Care Transitions	Health plans will implement specific care transition interventions. The transition of care process is designed to ensure that both planned and unplanned transitions are identified and managed by an ICT trained to address the member's needs and ensure smooth movement across the care continuum.	If health plans determine that the current IHSS authorization period of 7-14 days is too long and may put the member at risk of institutionalization or other adverse outcomes, will the health plans be able to assess members and authorize IHSS sooner?
Anthem Blue Cross	10	Enrollment	"Once enrolled in a demonstration site, beneficiaries will have another opportunity to opt-out after a six-month stable enrollment period during which health plans must ensure continuity of care."	By stable enrollment period, does DHCS mean six months of continuous enrollment? Is the period during which plans must ensure continuity of care the period immediately following a member's election to opt-out after six-months of continuous enrollment?
Anthem Blue Cross	10	Enrollment	"Based on stakeholder feedback, the State will identify any beneficiary categories that may opt out during the six-month stable enrollment period."	When will DHCS identify the beneficiary categories that may opt-out during the six-month period? Will this opt-out provision mean that certain beneficiaries will be able to opt-out at any time following enrollment? If so, we suggest that these beneficiaries not be enrolled in the demonstration since the care provided to these individuals will not be reflective of the integrated care model that is the foundation of the Duals Demonstration.
Anthem Blue Cross	26	Enrollment	The draft proposal states the HRA process will include review of historical Medi-Cal and Medicare utilization data.	Does DHCS have an update on the timeline for provision of Medicare claims data to health plans? Will Medicare data be provided with the enrollment file? What specific data elements will be provided in the Medi-Cal data file? When will selected health plans receive Medi-Cal data?
Anthem Blue Cross	33	Enrollment	In conjunction with the passive enrollment process, the State is seeking federal approval to establish a six-month minimum stable enrollment period for beneficiaries who enroll in the demonstration.	For passive enrollment, is DHCS planning to develop an algorithm to assign the membership between the demonstration plans in each county? If yes, when will the details of the algorithm be released? Is there a plan to add a quality score factor to the algorithm? If DHCS is considering adding a quality score factor, then Anthem recommends DHCS consider Medicare STARS ratings as well as HEDIS rates if both scores are available.
Anthem Blue Cross	32	Enrollment	California will use a passive enrollment process through which dual eligible beneficiaries may choose to opt out of the demonstration. Those who do not opt out will be enrolled in the demonstration for an initial six-month stable enrollment period. Enrollment in the demonstration counties will be implemented on a phased-in basis throughout 2013.	Can DHCS please clarify what type of quality ratings will apply to the demonstration plans? Due to the nature of passive enrollment, a demonstration health plan's member satisfaction levels may be lower than what is currently seen in Medicare or Medicaid, and could thus impact a health plan's quality ratings overall. Anthem recommends that quality benchmarks that are developed for the demonstration plans take into consideration the possible impact of passive enrollment on member satisfaction.

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Anthem Blue Cross	3	Expected Outcomes	The State will work closely with CMS to provide strong monitoring and oversight of health plans, and to evaluate the demonstration's impacts on changes in quality and satisfaction, service utilization patterns, and costs.	Please define the data/reporting requirements for quality and satisfaction, service utilization patterns, and costs.
Anthem Blue Cross	29	Expected Outcomes	Further, the State is exploring ways to implement a rapid-cycle quality improvement system to monitor, collect, and track data, and use that data to make necessary program adjustments to ensure quality of care and for evaluation purposes.	Please define the rapid-cycle quality improvement system.
Anthem Blue Cross	29	Expected Outcomes	Demonstration sites will be accountable for provider performance and health outcomes within their systems. ... These entities will be required to share performance and outcome data with the State.	Please define the performance and outcome data requirements.
Anthem Blue Cross	35	Expected Outcomes	A coordinated and standardized state and federal monitoring/oversight mechanism and a dashboard of appropriate quality and outcome measures is critical for program success, as well as for public oversight.	Please define the monitoring/oversight mechanism including operational report requirements.
Anthem Blue Cross	27	Financing and Payment	CMS indicates it will require a performance based withhold of 1%, 2%, and 3% respectively for years one, two and three of the demonstration. The State is also considering quality incentives, in addition to the CMS required withholds. The State may integrate the Medicare withholds with any new measures to be determined under the three-way contract.	What are the performance criteria behind the withholdings? Moreover, Anthem recommends that DHCS and CMS consider innovative risk sharing approaches or bonus payments in lieu of withholding capitation to promote the delivery of quality care. We believe that risk sharing models provide stronger incentives for plans and providers to invest in the infrastructure needed, such as the increase use of technology, for improved efficiency in care delivery. We also believe it will be important to work with plans on the details of the risk sharing programs, such as the whether these programs will have both upside and downside risks.

Organization	Comment #	Page # of Proposal	Relevant Language	Proposal Draft Language & Comment
Anthem Blue Cross	17	Long Term Services and Supports	County social services agencies will continue to perform their current IHSS functions, including assessment, authorization, and final determinations of IHSS hours in accordance with statutory provisions for IHSS eligibility, on behalf of the Med-Cal managed care health plans. The CCI Trailer Bill language also reiterates this provision stating: In addition to the activities set forth in Section 14146.3(e)(1)(G), county agencies shall continue IHSS assessment and authorization processes, including final determinations of IHSS hours on behalf of the Med-Cal managed care health plans and in accordance with statutory provisions for IHSS eligibility.	In order to achieve full integration of services and maximize the ability to support members in their home, as well as to eliminate duplication of activities, the health plan needs to assess members and authorize IHSS. Will IHSS be included in the health plan's capitation for each demonstration year? If IHSS is included in the health plan's capitation for one or more years, what mechanisms can the health plan use to address IHSS utilization, given the health plan will not be performing the IHSS assessment, determination of need and authorization of IHSS hours? How will DHCS address situations when health plans determine there is a need for urgent access to IHSS and/or access to additional hours, but DSS does not authorize these services timely? How will DHCS address situations where health plans determine that IHSS is being utilized in excess of what is necessary to maintain a member safely at home? We suggest that health plans and counties be required to develop a transition process for IHSS assessment and authorization that may include contracting with counties and that this transition be completed by Year 2 of the demonstration .
Anthem Blue Cross	17	Long Term Services and Supports	DHCS proposes to develop a HCBS universal assessment process that will be separate from the health risk assessment process completed by health plans when members newly enroll. The proposal states: "Comprehensive health risk assessments and care planning. Demonstration plans will be responsible for an in-depth risk assessment process capable of timely identification of primary, acute, LTSS and behavioral health needs." The CCI Trailer Bill language states: In addition, in the third year, beginning January 1, 2015, managed care health plans and their contractors and home and community-based service providers, shall utilize the new universal assessment tool described in Section 14146.3(f) for all home and community-based services as defined in Section 14146.1(c).	We currently have a comprehensive and in-depth assessment (and annual reassessment) process that encompasses each of these types of needs. We intend to add additional assessment data based on the unique needs of new dual enrollees, including additional functional assessment content relevant to IHSS and other HCBS. A separate assessment is not consistent with our model of care. We suggest that plans be permitted to implement a single, comprehensive assessment process approved by DHCS.

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Anthem Blue Cross	20	Long Term Services and Supports	The flexibility in the use of the capitated payment under this demonstration allows managed care plans to provide an array of coordinated benefits and services similar to the set of benefits available under these waiver programs. This will allow beneficiaries not enrolled in the waivers to benefit from these models of care. For example, providing an assisted living benefit with occasional home health (similar to the current Assisted Living waiver) may be more satisfying to plan members and less costly to health plans than nursing facility placement. The State is considering options for how new enrollment in these waivers would be treated under the demonstration, and welcomes stakeholder feedback on this issue.	We concur that beneficiaries should have access to alternative services, such as the assisted living benefit with occasional home health services. Will demonstration health plans have the option to pay assisted living providers a per diem amount for services similar to those provided under the AL Waiver as an alternative to nursing home care when it is cost-effective to do so? Will demonstration health plans also have flexibility to provide IHSS in assisted living settings under the demonstration?
Anthem Blue Cross	21-22	Long Term Services and Supports	DHCS states that plans will be assuming responsibility for HCBS waivers, and these waivered services will become part of a plan's supplemental services, at which time the waivers will be phased out.	Once the waivers cease, what are DHCS' expectations concerning access to waiver equivalent services? Will health plans be required to cover all existing waiver services, or can plans develop service packages based on members' unique LTSS needs? Does DHCS intend to require that plans provide access to waiver-equivalent services at the same level as provided prior to integration of the HCBS waivers (i.e., enrolling the same number of recipients as previous years and maintaining some specified level of spending for HCBS waiver services)? Does DHCS intend that health plans deliver waiver equivalent or alternative services to additional members as supplemental services funded through savings?
Anthem Blue Cross	11	Marketing	The draft proposal states: "In addition, health plans may also partner with current providers and case managers to explain the benefits of participating in the demonstration."	We understand that states and CMS are working out specific guidelines related to outreach and marketing. When will specific guidelines and requirements be available that explain how the type of activity proposed here can be carried out by the health plan in compliance with state and federal requirements for Medicaid and Medicare outreach and marketing activities?

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Anthem Blue Cross	16	Mental Health / Substance Use	The draft proposal refers to close coordination and collaboration with county agencies which, in future years, could include full integration of county services through an integrated capitated payment. The draft proposal then states: "These integration strategies will build on the recovery model of care set forth in state statute. Health plans will contract with providers experienced in delivering that model of care within their networks directly or through contracts with the county mental health agency, which currently funds these programs. The strategies will demonstrate shared accountability based on agreed-upon performance measures and financial arrangements, such as incentive payments or shared savings structures."	Is it correct that this reference to contracting is applicable only to a future point in the demonstration when health plans will fully-integrate MH/SU services?
Anthem Blue Cross	11	Mental Health / Substance Use	The draft proposal states: "Demonstration health plans will have networks of medical and supportive service providers that are appropriate for and proficient in addressing the needs of their dual eligible members. This includes a broad network of LTSS providers, ranging from those offering home-and community-based services to those in institutional settings, as well as mental health and substance use service providers."	Similar to our previous question related to the MH/SU network, is it correct that this reference relates to those mental health and substance use service providers needed to ensure access to the Medicare MH/SU benefit and will refer to an expanded MH/SU network of specialty mental health and drug Medi-Cal providers, once these Medi-Cal MH/SU services are included in the capitation?
Anthem Blue Cross	8, 12	Mental Health / Substance Use	Under this demonstration, health plans will collaborate with county agencies to develop strategies for mental health care and substance use care coordination, which, in future years, could include full integration of county services through an integrated capitated payment.	In order to better manage the member's health, we recommend that county MH/SU services be carved into the demonstration. Anthem is very interested and willing to work with DHCS and other stakeholders on developing an appropriate transition plan.

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Anthem Blue Cross	14	Model of Care	The RFS included MOC elements that were modified by DHCS. The draft proposal states: “Plans’ Model of Care will include eligibility, protocols and guidelines on utilizing CBAS as a substitute for nursing facility care. Plans’ care management teams will authorize CBAS services and coordinate CBAS in relation to medical services and other LTSS needed by the beneficiaries.”	Our MOC addresses the 11 elements required by CMS. We understand from the CMS MOC training that our MOC is not to intermingle state-specific requirements with the CMS required elements. Does DHCS consider this requirement to be a state-specific requirement that should be included in the state-specific element section of the MOC submission template? Or does DHCS believe these kind of requirements are specific to the target population and can be included within 1 of the 11 elements rather than listed as a state-specific requirement?
Anthem Blue Cross	27	Network Adequacy and Care Continuity	The draft proposal states: Beneficiaries will have access to out-of-network Medi-Cal providers, for up to 12 months, for new members enrolled under the demonstration who have an ongoing relationship with a provider if the provider will accept the health plan’s rate for the service offered, or applicable Medi-Cal fee-for-service rate, whichever is higher, and the managed care health plan determines that the provider meets applicable professional standards and has no disqualifying quality of care issues.	1. Will the state provide information about the list of providers with whom the members have an ongoing relationship? 2. What are the professional standards that are being referenced? Are these health plan set standards or will CMS and/or the state define them? 3. Is the health plan required to authorize OON care for the entire 12 months or will there be other considerations that would permit OON authorization for a shorter time when clinically appropriate? 4. Please clarify whether the OON period is 6 months (related to the stable enrollment period on page 10 of the draft proposal) or 12 months. Comment - Permitting out of network will potentially create issues in the care management, especially in situations when the out of network provider wants to utilize their current referral provider group, which also could be out of network
Anthem Blue Cross	27	Network Adequacy and Care Continuity	The draft proposal states: “During the six month period, a beneficiary may continue receiving services from an out-of-network Medicare provider for primary and specialty care services if all of the following criteria are met: a) the beneficiary demonstrates an existing relationship with the provider prior to enrollment, b) the provider is willing to accept payment from the health plan based on the current Medicare fee schedule, and c) the managed care plan would not otherwise exclude the provider from their provider network due to documented quality of care concerns.”	We recognize that continuity of care is extremely important to this program. However, we feel there are situations in which the member may be better served with an in-network primary care provider. We want to work with DHCS to define these situations.

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Anthem Blue Cross	24	Other	Examples of improved beneficiary services that demonstration health plans described included adopting in-house care management systems; partnering with member advocacy and community groups, such as Independent Living Centers and local Promotoras, conducting repeated welcome calls to new beneficiaries, budgeting more time for these calls, enhancing member welcome materials, and developing new ways to disseminate this information.	For communications and member materials intended for a plan's existing members (not prospective members), we recommend that health plans be allowed to use a file and use process to help ensure communications are timely, relevant and address the timely needs of the Duals population.
Anthem Blue Cross	8	Target Population	Summary of Covered Benefits - HIV/AIDS Waiver Services	Is it correct that duals who have HIV/AIDs and who are not enrolled in AHF will have the choice of AHF or a demonstration health plan in demonstration areas where AHF provides services?
Anthem Blue Cross	8	Target Population	The draft proposal removes dual children and youth under age 18 from the demonstration.	Since CCS serves children and youth up to age 21, will CCS dually eligible children ages 18 through 21 have the choice of a CCS demonstration (in counties with a CCS demonstration) or a duals demonstration health plan?
SF IHSS Public Authority	1	1	"rebalancing"	Nothing to "re"balance - not balanced to begin with
SF IHSS Public Authority	2	2	Sentences about IHSS and high quality of life in the community; avoiding unnecessary insititionalization"	Suggest: "This demonstration aims to enhance the IHSS program's ability to help people live safely in the community with assistance; IHSS wil remian an entitlement.... "The second part of these sentences leaves the impression that IHSS is only about delaying or avoiding institutionalization..It is about keeping people safely in their homes, whether they are institutional LOC or not.
SF IHSS Public Authority	3	4	Summit planned….	Ideally, this Summit should occur BEFORE the demonstrations begin.
SF IHSS Public Authority	4	6	"…hire, fire, and manage their IHSS providers."	Add: "…manage their IHSS providers, whether trained or not and including family members."
SF IHSS Public Authority	5	6	"Enhanced hcbs."	It should be made clear that "enhanced hcbs" means adequate funding for and implementation of additional best practices beyond the current array of hcbs services. I.e., we have to allow for creative new approaches and services - not just increasing ACCESS to the current array, which may or may not be sufficient to meet needs to keep people our of institutions.
SF IHSS Public Authority	6	7	performance outcomes…quality measures	Identifying performance outcomes and q measures in the cons-directed mode will be very challenging - as I understand there are few models out there. But this will be crucial and stakeholder involvement is required.
SF IHSS Public Authority	7	7	"…will build on lessons learned from 3 recent transitions:" SPD, CBAS, Agnews.	As to SPD and CBAS, there has been barely enough time to get lessons from these - at least sufficient to inform the scale of the duals integration. And the Agnews project was done over a period of years with quite an infusion of funding (as I understand it) - not an expectation of savings in the first couple of years of closure.
SF IHSS Public Authority	8	7	"Each of these transitions…on these efforts in the implementation of this demonstration."	The focus on duals integration SHOULD, as stated, focus on careful planning, collaboration, and a transparent process…NOT implementation of an aggressive timeline and immediate cost savings.
SF IHSS Public Authority	9	9	"Managed care done well…."	"Done well" requires time, true evaluation and adequate rate development. CMS has reported that some states in the demonstration have requested a 2014 start date. California should do the same.
SF IHSS Public Authority	10	9	"…partnership with the county agencies that provide IHSS…"	The proposal should make explicit a partnership with IHSS public authorities.

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SF IHSS Public Authority	11	9	"…Accessibility."	It should be made explicit that "accessibility" includes medical office equipment that makes it possible for people with disabilities to get adequate care. Not to mention funding for them to obtain durable medical equipment in a timely manner as needed.
SF IHSS Public Authority	12	11	Provider Networks	IHSS public authorities should be mentioned as supportive services providers that are appropriate parts of health plan networks.
SF IHSS Public Authority	13	12	Benefit Design and Supp Benefits	Make clear that the listing of current M-Cal services does not preclude design and delivery of NEW hcbs benefits as it becomes clear they would be helpful. For example, IHSS providers (such as public authorities) should be specifically authorized to provide emergency services with reploacement home care workers). Or the idea of funding new technologies that assist in the home - but may present initial capital costs.
SF IHSS Public Authority	14	13	Model of Care	This listing of essentially new service delivery components will be costly at the inception. Again, how can "savings" be expected in the first couple of years of integration when new and additional parts of the system are being put in place?
SF IHSS Public Authority	15	14	"Health plans are encouraged to provide an active role for members…"	"Health plans MUST provide an active role for members…." This should include funding to educate and train consumers about how to effectively use managed care, manage their providers, etc. In the kind of new system being put in place here, consumers cannot be passive. Hospitalizations, etc., will be reduced when consumers are supported in being proactive.
SF IHSS Public Authority	16	14	"…specific care transition interventions… evidence-based"	Different levels of case management/care coordination must be put in place. For example, people with disabilities can be trained an employed as mentors to complement more formal case management. In some instances, peer-to-peer support can be as, or more, effective in supporting community living than professional case management - however well trained or intended.
SF IHSS Public Authority	17	17	IHSS program structure…	For the past 15+ years, IHSS public authorities have been the enitities that spawned positive change in IHSS services. Their structure may change/evolve in this new integration era, but their accomplishments should be explicitly acknowledged and built upon. Specific reference should be made to include them in the early transition years.
SF IHSS Public Authority	18	18	Evidence-based Practices…"clinical guidelines…"	Evidence-based practices must include social services models. This section seems tilted to reliance on medical practice and expert researchers. With all due respect, these groups are not always attuned to unique aspects of the social service, consumer-directed mode.
SF IHSS Public Authority	19	18	"A telephone survey of 463…"	Given the size of IHSS alone, this seems a very small sample.
SF IHSS Public Authority	20	20-21	Money Follows the Person	Resources to re-establish a houselhold - a good example of the kinds of creative service addition that should be allowed for in the rate development process.
SF IHSS Public Authority	21	23	"…another 122 called in to discuss…"	The State is to be commended for its efforts to reach stakeholders. However, I attended both the Cons Protections and LTSS meetings and while there may have been that many folks on the phone, not nearly that many participated. Additionally, this is a complex arena and many consumers did not understand the implications of what was being discussed.
SF IHSS Public Authority	22	24	"CA Collab….policy issues around aging."	Add: "…aging and disability."
SF IHSS Public Authority	23	25	Consumer direction in IHSS	Are there any duals who are not on IHSS? If so, can they not also be offered the consumer-directed mode?
SF IHSS Public Authority	24	25	"Contingent upon available private…"	Funding to assist duals "in understanding their health care coverage options" should not be "contingent". Educating consumers should be part and parcel of the rate and/or funding of this should be required.
SF IHSS Public Authority	25	26	Re: network adequacy	Must be in place BEFORE a health plan is begins to deliver fully integrated services.
SF IHSS Public Authority	26	27	"The state will work with CMS to develop a cap rate structure…"	Process must include stakeholders.
SF IHSS Public Authority	27	28	"Incentives for physicians…."	Does this mean increased reimbursement for docs? Another cost, even though the proposal anticipates immediate savings?

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SF IHSS Public Authority	28	29	Performance measures "…implementable by the State…"	Add: and implementable by the health plan.
SF IHSS Public Authority	29	29	"An incr in the number…receiving care coordination"	Why would this number, in and of itself, be an improvement target? Isn't care coordination reserved for those most at-risk? Might encouragement of "self-care coordination" actually reduce this number?
SF IHSS Public Authority	30	30	"…will result in expected savings in the short-term…"	This conclusory statement is, I think, unrealistic - unless services are not provided. As stated later in the paragraph: "The real potential of this demo…will be felt over several years."
SF IHSS Public Authority	31	33	"…the state already has in place most of the elements require for successful implementation…"	The elements may be there. Successful implementation if much more complex. This proposal will directly affect literally hundreds of thousands of people is and moving on too aggressive a timeline to assure continuity of care.
SF IHSS Public Authority	32	34	"…3) slow the cost growth for M-care and M-Cal…"	With the expansion of services anticipated, even with reduced hospitalizations, this is not a realistic expectation.
SF IHSS Public Authority	33	34	"Further, some hcbs have been frozen or reduced in recent years as a result of funding reductions."	All the more reason to expect that savings will not be achieved early on in the integration of LTSS and hcbs into managed care.
SF IHSS Public Authority	34	35	"…LTSS network adequacy will be est'd during the 3-year demo."	During? Isn't this supposed to be in place before demos are approved?
SF IHSS Public Authority	35	35	Ambitious Timelines	I suggest CA request a delayed implementation to at least 2014, allowing for change to be better understood and continuity of care more realistic.
San Diego County	1	1	Coordinate state and federal benefits and access to care across care settings, improve continuity of care, and use a person-centered approach.	How is this going to be achieved if duals in IHSS and MSSP are able to opt out for their Medicare benefit?
San Diego County	2	1	"Coordinate"	Needs definition.
San Diego County	3	1	Increase the availability and access to home-and community-based alternatives.	Will there be an expansion of the MFP demonstration to ensure service availability for SNF transitions?
San Diego County	4	2	Opt out of the demonstration	Will those people still get IHSS?
San Diego County	5	2	"Beneficiaries will be informed"	Who will inform beneficiaries?….many models have proved ineffective, ex: clients ignore Medi-cal re-cert packets, ex: chaos when the ADHC system was changed. No information to supporting agencies so that they could help clients. What will be systems used to inform? Mail-many will ignore, Phone-many can't understand over phone, don't even think about Internet, the clients don't have access or abilities.
San Diego County	6	3	"Robust networks of providers"	Needs definition. Problems with Managed Care systems in the transition of ADHC, only 2 doctors participated in East County and La Mesa area.
San Diego County	7	6	"Person-centered care planning"	It is great to have an inter-disciplinary team but someone has to own the responsibility. Will each discipline have a section of responsibility? How many disciplines, since this includes medical, MSSP, IHSS, and…..?
San Diego County	8	6	Health plans will provide care management and care coordination for beneficiaries, including interdisciplinary care teams, across the full continuum of medical and social services.	Will the health plans receive training on care coordination and interdisciplinary care teams? Although that are used to care management, this requires a different type of skill set.

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San Diego County	9	7	Demonstration is considering excluding people with a SOC who live at home due to complexity of adjusting the Medicare capitation payment mid-way through the month, after they have met their SOC.	How does this work for beneficiaries who have both IHSS and SOC?
San Diego County	10	7	Share of Cost beneficiaries	IHSS serves many SOC beneficiaries - if they are excluded from the demonstration but still receiving managed care for their LTSS, how will their medical care be coordinated?
San Diego County	11	7	Share of Cost beneficiaries	Means all of MSSP's SOC clients will be eliminated from participation? What if they start in the 6 month stable enrollment portion and drop into a SOC during that time? Only SNF SOC can participate?
San Diego County	12	7&8	Share of Cost, Children & those with other health coverage	Do the IHSS recipients under these 3 categories have the ability to Opt out of the demonstration? This is not clear. An extensive list of who is mandatory and who can opt out would be helpful
San Diego County	13	7 & 8	"Certain beneficiaries…"	What happens to them? Is there a parallel IHSS program for them?
San Diego County	14	8	Developmentally disabled are carved out.	So our current client population of developmentally disabled will not be cared for by MSSP service?
San Diego County	15	8	Based on stakeholder feedback and the specific care coordination needs of children, dual eligible beneficiaries under age 18 will not be enrolled in the demonstration.	What about children who are IHSS recipients? While this exclusion makes sense in general, it would make sense to include children receiving IHSS.
San Diego County	16	9	The State reviewed each health plan's proposed model for coordinating care for the total needs of beneficiaries, including medical, behavioral, social, and long-term services and supports.	Will each health plan in San Diego have their own model or will all four agree to one care coordination model?
San Diego County	17	9	Demonstration sites shall ensure availability of all services in a member's care plan.	This is a very broad statement. How is the State going to ensure that there are adequate community based services like housing and transportation available in the Demonstration Counties?
San Diego County	18	10	Enrollment Process	If client doesn't choose a Managed care or choose to opt out, they will be 'auto enrolled in a demonstration health care plan'. Who picks the plan? Do they consider location and doctors in place?
San Diego County	19	10	Mandatory enrollment	Mandatory enrollment is 'pending' legislature….none yet and they may refuse….if so is this all a moot issue? Does this mean that all potential enrollees are also entitled to MSSP services. We only serve 550 currently with a max of 578 and a staff of 19. Who will serve those over 550? Will a wait list be permitted? Is the plan going to screen for only the most in need of MSSP? How will they screen as they really won't know unless a home visit is done.
San Diego County	20	10	The State will use a unified, passive enrollment process through which dual eligible beneficiaries who do not make an affirmative choice to opt out will be automatically enrolled into a demonstration health plan.	How much time will a beneficiary be given to opt out of the demonstration? How is this information going to be communicated to dual eligible beneficiaries?
San Diego County	21	11	Outreach - "plans may partner with current providers and case managers to explain the benefits of participating"	If that might be MSSP CM who/when/how will they be trained so they are using the correct verbiage and really understand the process/program so they explain properly? Concerns because CM are carrying a heavy load right now. If they are going to participate in the enrollment process, which is triggered by birthday month, this will mean extra home visits as the idea of doing this effectively with our client base over the phone is unrealistic.
San Diego County	22	11	Supportive service providers	What about other supports that are not currently Medi-Cal providers?
San Diego County	23	11	24/7 access to non emergency	Does this include IHSS?

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San Diego County	24	12	The extent of a health plan's ability to offer value-added supplemental benefits such as these will be better understood during the rate development process.	If the needs and preferences of the beneficiary are truly at the center of the care plan, the health plan will have to receive a capitated rate that supports the provision of unique supplemental benefits. Plans should retain maximum flexibility to order services not currently covered in order to prevent premature placement/hospitalization.
San Diego County	25	12	Additional benefits	Who will assess for these additional benefits?
San Diego County	26	12 & 13		P12 (mid page paragraph) - Contradicted? By P 13 (second paragraph)? Can't take away benefits currently received by clients?
San Diego County	27	13	"Achieving optimal health outcomes"	Will mobile docs be provided? Refers to above comment. Also many of MSSP clients will not receive medical care if this isn't provided. They either refuse because of medical conditions that make a trip impossible or are bedbound.
San Diego County	28	14	Attempt to gather assessment information	No in home visit? This will result in false assessments as we see every day in the senior's reluctance to admit they need help. Observation and relationship must be established.
San Diego County	29	14	ICT may include the designated primary physician, nurse case manager, social worker, patient navigator, county IHSS social worker (for IHSS consumers), pharmacist, and other professional staff within the provider network.	What about the HCBS provider that is not part of the health plan provider network but is providing a supportive service to the beneficiary ?
San Diego County	30	14	Health plans will implement specific care transition interventions.	Will utilization of evidence based models be required?
San Diego County	31	14	ICT	Will an ICT be mandatory for every IHSS client? These teams will require staff time that would otherwise be used for their regular case management duties.
San Diego County	32	14	Care Transitions	IHSS needs to be in place when client arrives home, not weeks later after Medi-cal gets around to changing their aid code to the correct one changing from the SNF code.
San Diego County	33	15	Greater use of electronic health records throughout the provider network, including web-based sharing of care management plans and updates.	It will be important that HCBS providers have access to these records and can update care plans. This will ensure communication and coordination among everyone involved in the care, treatment or support of the beneficiary.
San Diego County	34	15	Electronic technology	Will Legacy CMIPS/CMIPS II interface w/ health plans' systems?
San Diego County	35	15	Use of Technology	Please note two data systems in place---care managers will spend all their time in data entry. State currently has specific requirements in place for data systems for MSSP services.
San Diego County	36	15 & 34	New system being developed to integrate data elements	Data sharing will need to be both ways - from counties and Public Authorities operating IHSS/MSSP and Behavioral Health to health plans as well as from plans to counties/Public Authorities. This needs to be codified in law so that data sharing can occur from the beginning of the project.
San Diego County	37	16 & 25	Consumer & self directed	What about people who are non-self directing?
San Diego County	38	17	The demonstration and Coordinated Care Initiative would allow health plans to enter into performance-based contracts with counties, and contract with counties for additional assessment of IHSS.	What is their definition of performing?
San Diego County	39	17	Performance based contracts/Contract with counties for additional hours	Who will be funding these costs? This may result in a huge impact to the current IHSS workload.
San Diego County	40	17	Performance based contracts with counties	More clarity is needed on what is envisioned here - what is the performance that will be sought by health plans from counties to merit the additional use of capitated funding? Will counties be on the hook to pay a share for these services as is now done?

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San Diego County	41	17	Universal assessment process	Begins no earlier than 2015, so what will be used prior?
San Diego County	42	17	IHSS program	Caseloads are currently too high to offer this type of case management
San Diego County	43	21	Multi-purpose Senior Services Program (MSSP)	The transition of MSSP is not clear as written; more detail and information is needed. Will Medi-Cal waiver requirements still be necessary to follow? Will plans be held to a set # of client slots as is now the case?
San Diego County	44	21	Plan specifically states that by the third year of the Demonstration, MSSP will cease to exist as a separate, independent program from the managed care plans.	The plan specifically doesn't say this about IHSS. Does this mean IHSS will stay with the County indefinitely?
San Diego County	45	25	IHSS beneficiaries will be able to hire, fire, and manage their IHSS provider, as currently allowed in California's IHSS program.	What provisions are being made to ensure that IHSS beneficiaries are competent to perform this function and what insurance will there be that the provider is trained to provide the level of care required? How will plans ensure services are being delivered as authorized?
San Diego County	46	25	Notification process	Need to inform IHSS recip. about consequences of opting out- no IHSS.
San Diego County	47	25	Written notice 90 days before enrollment	Most clients won't respond as they don't respond now to re-certs for Medi-cal.
San Diego County	48	26	In person assessment	Contradicts previous statement that doesn't include in-person. Will in-person be used or not?
San Diego County	49	26	Monitor an appropriate provider network that includes an adequate number of specialists, primary care physicians, hospitals, long-term care providers and accessible facilities within each service area.	Please define adequate number of long-term care providers. Who determines what is adequate in a demonstration county?
San Diego County	50	28	Performance based withhold of 1%, etc.	What are performance based withholds and quality incentives. These terms should be further defined.
San Diego County	51	28	The state is also considering the use of risk sharing and risk corridors, to create a mechanism for sharing the risk of allowable costs between the state and health plans.	This will be key to ensuing that high risk beneficiaries receive the care and support that they need to remain in the community.
San Diego County	52	29	Increase number of clients	Increase number of clients….is a potential target for performance. How will MSSP handle more clients?
San Diego County	53	30	Savings to be shared equally between State and feds.	It appears that counties will also be required to pay for a share of the cost of services via the IHSS MOE. What discussions are occurring for counties to also share in a proportionate amount of the savings? Is this the 'performance-based' contracting? More information is needed.
San Diego County	54	33	Expansion plans	Implementation timeline is too ambitious.
San Diego County	55	34	"State assumes that it will receive 50 percent of the combined Medicare and Medi-Cal federal and state savings from this demonstration"	To do what with? Will it go back to supporting seniors? Where does the other 50% go? To incentives to the managed care to cut these costs?
San Diego County	56	34	Data sharing btwn health plans & county	Who's going to create the protocols, policies, etc.?

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San Diego County	57	35	The state is working with stakeholders and local agencies to develop a coordinated model that calls for accountability and also allows for local flexibility.	Local flexibility is key and needs to drive the design on the model in the demonstration counties rather than forcing a universal design approach.
San Diego County	58	45	72% are family member providers	Will they continue to be paid as IHSS providers?
San Diego County	59	49	6: Applicant will coordinate with relevant entities to ensure coverage of the entire county's population of duals.	How will MSSP handle the influx without more resources, even recognizing that all dual may not need MSSP services?
Disability Rights California		2	"these plans also have experience providing Medicare managed care"	Some of have this experience; not one has experience providing or managing all LTSS
Disability Rights California		3	"if is receives State Legislative approval"	Should say this on Page 1 and clarify the differences between the proposals - not just number of counties
Disability Rights California		3	"will use a passive enrollment…beneficiaries may choose to opt out"	We oppose passive enrollment.
Disability Rights California		3	"enrolled for an initial six-month stable"	Should say this is dependent on CMS approval;suggest use the more straightforward "lock-in"
Disability Rights California		3	"will build on lessons learned"	But the evaluation will not be done until December. What lessons have been learned - the problems and lessons should be called out.
Disability Rights California		3	"will include person-centered …."	Need definition of person-centered; it's clear that people mean different things by this. Please see DRC 1,a Page 2
Disability Rights California		3	"administrative processes that - to the extent possible"	What does "to the extent possible" mean in this context? Please see DRC 8, Page 11
Disability Rights California		4	"state will work closely with CMS..monitor..oversight"	Based on what, when, how…what role for stakeholders
Disability Rights California		4	"ongoing stakeholder involvement"	Not enough mandated role for consumers;Please see DRC 2, Page 3
Disability Rights California		5	references to stakeholder meetings	Should note that these meetings dealt only with the 4-county pilot - not the CCI. Lock-in was never discussed; mandatory enrollment in Medi-Cal was not part of the discussion.
Disability Rights California		7	"pairing experienced managed care plans"	Almost none of these plans have experience managing LTSS
Disability Rights California		8	"meaningful involvement will be required"	Will the state require what the stakeholders define as meaningful?
Disability Rights California		8	"incentives for greater use of HCBS"	Including services not now available in Medi-Cal
Disability Rights California		8	"hospitalization is often a precursor"	Could clarify to state what % of nf admissions in CA are from hospitals

Organization	Comment #	Page # of Proposal	Relevant Language	Proposal Draft Language & Comment
Disability Rights California		8	Enhanced home- and community-based services (HCBS). An integrated approach will create financial incentives for greater use of HCBS, such as IHSS, for those at-risk of hospitalization and long-term nursing home placement.	Proposed language: Enhanced community long-term services and supports (LTSS). An integrated approach will create financial incentives for greater use of community LTSS, such as IHSS and HCBS, for those at-risk of hospitalization and long-term nursing home placement. Comment: Current federal terminology seems to limit HCBS to the types of services that are available under HCBS waivers. It is unclear whether all IHSS services would be included under HCCBS waiver services. LTSS seems to be the broader term, which includes IHSS.
Disability Rights California		9	"Each of these transitions required careful planning, etc"	
Disability Rights California				The Agnews closure received careful planning; the other transitions were not comparable to Agnews.
Disability Rights California		10	Share of cost	We need more information about how share of cost will work. Please see DRC 7e i.
Disability Rights California		11	Developmentally disabled beneficiaries	Needs more clarity on what services plans will manage and how they will coordinate with Regional Centers
Disability Rights California		11	"managed care done well leads to high quality care"	Any citation for this; any examples in California?
Disability Rights California		12	"The selected plans demonstrate…business integrity…high quality service delivery"	Please see NSCLC report which documents the opposite. What measure of quality does the state use to substantiate its conclusion?
Disability Rights California		12	"partnership with county agencies"	No mention of Public Authorities and their services.
Disability Rights California		Page 13	California proposes to implement"	Suggest reversing the order; list the four approved under current law first.
Disability Rights California		13	Enrollment in the demonstration is optional…can opt out for Medicare benefits.	If it's optional, it's for Medi-Cal AND Medicare.
Disability Rights California		13		Should say somewhere that beneficiaries will have a choice of at least two plans.
Disability Rights California		13	"will be automatically enrolled"	Using what system? And what is the goal re: % of beneficiaries who actually choose a plan between the two offered.
Disability Rights California		13	Further, under the proposed Initiative, once enrolled in a demonstration site, beneficiaries will have another opportunity to opt-out after a six-month stable enrollment period during which health plans must ensure continuity of care.	Proposed language: Further, under the proposed Initiative, once enrolled in a demonstration site, beneficiaries will have an opportunity to opt-out on a monthly basis. Comment: A six-month lock-in period is not consistent with optional enrollment. In any event, there should be lock-in exceptions consistent with Medicare exceptions, such as: --The beneficiary joined a plan, or chose not to join a plan, due to an error by a government or managed care plan employee. --The beneficiary joined a plan, or chose not to join a plan, due to receipt of misinformation about plan benefits, including prescription drug benefits, covered under the plan.
Disability Rights California		13	"beneficiaries ..opportunity to opt-out after six month"	This applies only to Medicare, correct? When do people get to choose a different health plan under the Demonstration?

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Disability Rights California		15	Sites will also be responsible for all Medi-Cal State Plan benefits and services, including long-term institutional, and home- and community ba	Proposed language: Sites will also be responsible for all Medi-Cal State Plan benefits and services (except DD and AIDS waiver services) including long-term services and supports (LTSS) in institutions and in the community, and nonmedical transportation, including: Comment: Cost savings will free up funds to enable individuals to move from institutions to the community. These funds should be used to provide services currently available under HCBS waivers. In addition, nonmedical transportation must be provided to all Medi-Cal beneficiaries as an administrative requirement. There is no reason why this requirement should not be delegated to the managed care plans.
Disability Rights California		15	health plans will provide 24-7 access…	This seems out of place; paragraph is kind of a catch-all
Disability Rights California		15	"innovate health plans..analysis..cultural competency"	Shouldn't they all demonstrate readiness in cultural comptency and adequacy of non-medical providers?
Disability Rights California		16		
Disability Rights California		17	"medical necessity standards will not be restricted"	What does this mean, to not restrict a restriction?
Disability Rights California		17	Model of care includes:	No mention of social model, functional assessment, consideration of non-medical needs
Disability Rights California		17	"needs vary greatly depending on…"	must include personal preference
Disability Rights California		17	achieving optimal health outcomes	what does this mean and how does it include non-medical criteria
Disability Rights California				Must acknowledge that members can refuse any services, including coordination
Disability Rights California		18	Comprehensive risk assessment	Please see note below about assessments. What assessment tool, used by whom, for non-medical/LTSS needs? The plans have NO experience with this. Should be an outside conflict of interest free assessor.
Disability Rights California				Does the consumer have to consent to the care plan?
Disability Rights California				Does the consumer get offered the services indicated in the care plan?
Disability Rights California		18	"Some plans already outreach ..most vulnerable members"	What does this mean?
Disability Rights California			Plans are encourage to provide role for members	They MUST provide a role and the accommodations needed for members to participate unless the member declines to participate. That is key to person-centered.
Disability Rights California			Model of care reflects "value of the beneficiary and potentially his or her caregivers"	Must reflect the preferences of beneficiary and any designee…without preference for the caregiver, who may or not be the designee.
Disability Rights California			"Beneficiary may choose to limit role of caregivers"	There must not be a default inclusion of anybody, from which the beneficiary has to opt out.
Disability Rights California		19	Care transitions	"transitions" seems to be used here to mean a move from one location to another; if that's so, should be explicit

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Disability Rights California				What is a "complex" transition?
Disability Rights California		20	Health plans will be responsible for providing enrollees seamless access to the full range of mental health and substance use services currently covered by Medicare and Medi-Cal.	Proposed language: Health plans will be responsible for providing enrollees seamless access to the full range of mental health and substance use services currently covered by Medicare and Medi-Cal. Health plans will be responsible for providing the full range of mental health services for enrollees who are not eligible for specialty mental health services through the Medi-Cal Mental Health Plans (County behavioral health department). Comment: The second sentence should be added to ensure that plans meet their responsibility for providing mental health services for enrollees who have been found ineligible for specialty mental health services by the Medi-Cal MHP
Disability Rights California		20	Health plans will ensure warm hand-offs and follow-up care for coordinating needed behavioral health services.	Proposed language: Health plans will ensure warm transfers and follow-up care for coordinating needed behavioral health services. Comment: The term "hand-off" is disliked by consumers because it sounds like dumping.
Disability Rights California		20	Several innovative health plans contract directly with the county behavioral health agencies to ensure seamless care delivery.	Proposed language: All plans must have MOUs with the Medi-Cal MHPs (county behavioral health agencies) to ensure seamless care delivery. Several innovative health plans contract directly with the county behavioral health agencies to ensure seamless care delivery. Plans must not set up behavioral health plans that have the effect of preventing enrollees from accessing specialty mental health services to which they are entitled from Medi-Cal MHPs. Comment: MOUs between Medi-Cal managed care plans and Medi-Cal MHPs are currently required. Title 9 CCR §§ 1810.225.1, 1810.370. This should be made clear to the plans in this document. The last sentence is needed to ensure that plans do not enter into contracts with behavioral health plans that have the effect of freezing enrollees out of receiving Medi-Cal specialty mental health services because of Medicare rules. This happened when CalOPTIMA first set up its D-SNP.
Disability Rights California		20	Use of technology	No reference to HIPAA or other privacy laws
Disability Rights California			"new system being developed"	By whom?
Disability Rights California		20-21	Several are supporting efforts to co-locate behavioral health and primary care services, and others are working with behavioral health administrative service organizations to coordinate services across the care continuum.	
Disability Rights California		21	For seriously mentally ill beneficiaries receiving care from county specialty mental health plans (1915b waiver services), or beneficiaries with substance use issues, close coordination between health plans and county agencies will be necessary.	

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Disability Rights California		21	These integration strategies will build on the recovery model of care set forth in state statute. Health plans will contract with providers experienced in delivering that model of care within their networks directly or through contracts with the county mental health agency, which currently funds these programs. The strategies will demonstrate shared accountability based on agreed-upon performance measures and financial arrangements, such as incentive payments or shared savings structures.	Comment: Excellent!
Disability Rights California		21		
Disability Rights California		22	Eligibility for IHSS….	Excellent
Disability Rights California		22	"A grievance and appeals process"	Should specify the current process if that's what's meant.
Disability Rights California		22	IHSS assessments..in conjunction with	What does this mean? The managed care staff goes to the consumer's home?
Disability Rights California		22	"including IHSS hours above the …limits"	and tasks not currently authorized by IHSS (e.g. reading for the blind)
Disability Rights California		23	Home- and community-based Universal Assessment process.	See the CE Reed and Associates report entitled, "Analysis of State Approaches to Implementing Standardized Assessments" April 2012. This report recommends the need for a uniform, face-to-face LTSS assessment that is standardized and automated and collects common data elements, addresses consumer needs and protections, develops risk adjustment methods and rates setting, manages expenditures, measures services, and supports quality outcomes. According to DHCS' current proposal, a HCBS assessment process will not be implemented until January 2015. There are no provisions that the data will be automated or used for critical outcome and monitoring purposes. Without a clear assessment process which will be used to address consumers' LTSS needs and outcomes, having Managed Care plans take over LTSS, such as MSSP and HCBS waiver programs is premature. See DRC principles 4-6 and 19.
Disability Rights California		23	Process shall be implemented no earlier than	What assessment process is in place for non-IHSS LTSS before the new one is in place?
Disability Rights California		23	"apply evidence-based clinical guidelines"	How does this apply to non-medical LTSS?
Disability Rights California		24	telephone survey..of those who answered	how many people answered?
Disability Rights California		24	Four percent of the beneficiaries…	in the telephone survey or in the whole spd population?

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Disability Rights California		24	State has been incorporating these lessons	Examples of lessons would be helpful
Disability Rights California		24	enhanced outreach…around MER process"	We were told there is no MER process?
Disability Rights California		25	"phone calls ..not adequate"	What will be done instead, and by whom?
Disability Rights California		25	Plans will have had many months…	What do the preliminary results of the CHCF study tell us?
Disability Rights California		25-26	County Specialty Mental Health Services and Substance Use Services	
Disability Rights California		25-28	Waivers	The current waiver caps and slots should not limit the plans from providing waiver services to anyone who needs them.
Disability Rights California		26	Currently, Medi-Cal managed care plans must have appropriate mechanisms, including an MOU, to coordinate with County Mental Health Plans for individuals not needing specialty mental health services.	
Disability Rights California		27	MSSP will cease to exist…	What about people who opt out or are exempt from the demonstration? if waiver services become a managed care benefit, they still need to be available to those people who opt out or get exempted (there needs to be an exemption process). We are seeing with CBAS already that people are choosing NOT to enroll in managed care and get CBAS because they will (or think they will) lose their Medicare primary care docs.
Disability Rights California		28	During the Demonstration…	This sentence conflates the Demonstration with the CCI, saying people will at least be enrolled in Medi-Cal managed care
Disability Rights California		28	State is considering….	Assumes approval of CCI; otherwise, what about people who opt out who qualify for waiver services?
Disability Rights California		29	Stakeholder engagement	None of these meetings were about the CCI
Disability Rights California				
Disability Rights California		31	Americans with	Disabilities Act
Disability Rights California		31	California collaborative	the collaborative focuses on LTSS - not on aging
Disability Rights California		32	Self-direction	decide whether, how and what LTSS to receive
Disability Rights California			access to services which	meet their needs (omit "limitations"
Disability Rights California		33	Notification and enrollment	When will the state develop all of this and how does this fit into the timelines?

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Disability Rights California		33	inform through a notice written at no more	must be in the language the beneficiary understands, must be available in alternative formats
Disability Rights California		33	who they can contact	who will that be?
Disability Rights California		34	Health risk assessment	Who is doing the LTSS/social assessment, using which tool?
Disability Rights California		34	State will require…access to provider who comply	Excellent…must include the facilities/services of the health plan itself. This is different from what the readiness section says - this is better.
Disability Rights California		34	Monitor an appropriate provider network	The provider network must be high quality; eg NOT poor-performing nursing homes; please see DRC 11 i. P 18
Disability Rights California		34	Employ care managers directly...	What are the qualifications of the care managers? Do they do the assessments? Who decides who services the member will be offered?
Disability Rights California		35		We advocate for an independent ombudsman.
Disability Rights California		36	"high quality ..care…reduce costs"	and what if high quality care costs more?
Disability Rights California			State is considering quality incentives	What are the measures of "quality"?
Disability Rights California			State is considering use of risk sharing..corridors	Please see DRC 10, Page 16
Disability Rights California		37	Expected outcomes	Need role for stakeholders, including consumers
Disability Rights California		38	Rapid-cycle quality system	Yes - and must be used to halt enrollment if necessary
Disability Rights California			Potential improvement targets	Items 1 and 3 are givens: people don't have these services now, so any increase will be seen as an improvement
Disability Rights California		39	Each health plan shall have a process..	This is good, but role must be expanded
Disability Rights California		39	Better coordination…result in expected savings	How will we know if members are getting the appropriate services, and that plans are not shaving services for short-term savings?
Disability Rights California		41	DHCS functions…	What is the capacity of DHCS to manage? Why will it work better than the spd enrollment?
Disability Rights California		41	CDSS will administer a revised quality monitoring program	What is this? This is the first we're hearing about this.
Disability Rights California		42	Six month lock in	We oppose lock-in. The state should find out why people are "churning" instead of locking people in.

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Disability Rights California		42	Section 1115 waiver need for flexibility	Would like specifics on this.
Disability Rights California		44	Second, health plans need	But the demonstration is voluntary, so the goal of passive enrollment is to make it difficult for people to opt out?
Disability Rights California		44	if the DOF determines..state will discontinue	The only criterion is cost, not quality. If the FFS is dismantled, what will the state return to?
Disability Rights California		45	Data sharing..	If the program is voluntary, and beneficiaries have a choice of provider, how do the plans hire staff, etc?
Disability Rights California		45	It is anticipated…LTSS network adequacy..	If the measures don't exist, how do we know if the networks are adequate going in?
Disability Rights California		46	Ambitious timelines	We strongly urge the state to delay even the four-county pilot because of all the work still to be done.
Disability Rights California				
Disability Rights California				
Disability Rights California		54	Capitation rate setting	When will the plans know their rates?
Disability Rights California			Waiver submitted..mandatory Medi-Cal	This applies only if CCI is enacted, correct? Otherwise it's voluntary.
Disability Rights California		55	Enrollment materials	When are these developed, translated, etc?
Disability Rights California		60	In fee-for-service, these services are subject to a limit of two visits per month….	Proposed language: In fee-for-service, these services are subject to a limit of two visits per month (except that psychiatrist services [physician services] and services to individuals under age 21 are not subject to this limitation)…. Comment: The fee-for-service limitation of two services per month does not apply to all services.
NSCLC	1	1	Demonstration goals: Optimize the use of resources	The demonstration seems less designed to optimize resources then to decrease current Medi-Cal expenditures. The proposal should be explicit about that since the Administration has been. For example, the Trailer Bill Language indicating that the demonstration would end if savings are not achieved immediately. We note that there is not similarly strong language related to ensuring quality and increased access to home and community based services.
NSCLC	2	2	Rigorous selection process to identify plans with the requisite qualifications and resources best suited to participate	The selection process does not appear to be rigorous. All plans but one were selected. Multiple plans selected have poor performance records in both programs. And several plans failed to include information required in the RFS application. See more detailed comments in our comment letter and our report, "Assessing the Quality of California Dual Eligible Demonstration Health Plans."
NSCLC	3	2	Managed FFS models	The state, at the persistent request of stakeholders, has been promising to explore managed FFS models for two years with little to show for it. We believe more should be done in this area. A true demonstration would include a Managed FFS county in the initial year for the sake of comparison to the capitated risk model.
NSCLC	4	2	Enrollment process	We object to the proposed enrollment process. See our letter comments for more details.
NSCLC	5	4	Summit on SPD learning	When will this summit be held? Time is running out to absorb the lessons of that process.
NSCLC	6	5	Responsibility for dual eligibles	While it's true that no *single* entity is responsible for dual eligibles now, the proposal fails to mention that multiple entities are responsible - the Department of Health Care Services, the Department of Social Services, the Centers for Medicare and Medicaid Services and more. The state in particular has long been responsible for ensuring the needs of Californians are met and that they receive the services to which they are entitled. The state has also long had the incentive to provide care in less restrictive, less expensive settings. The state, and the other entities will remain responsible for this population even under the demonstration.

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NSCLC	7	5	New systems should support and build on existing programs	We agree.
NSCLC	8	5	Partner health plans experience	This section should be clear that the experience to date has been primarily limited to coordinating medical services. And that the bulk of the experience in Two-Plan and GMC counties is with children and families. Experience with the SPD population is still brand new in those counties. Also, experience in the Medicare program is limited, especially among plans selected for the demonstration. In total, the 8 plans selected for the four counties currently provide Medicare benefits to just 35,544 duals - only 6% of all duals in their counties.
NSCLC	9	5	Stakeholder process	The stakeholder process must be robust at the state level as well. This process should not be farmed out to managed care plans. DHCS and CMS, the entities that will monitor and oversee these plans, must have an independent process for gathering input and feedback.
NSCLC	10	6	Person-centered planning	The proposal implies that a person-centered approach will result from the new financial incentives imposed on plans. That is not good enough. There must be clear standards and evaluation measures for the provision of person-centered care.
NSCLC	11	6	Enhanced HCBS	The proposal again relies on financial incentives and the theory that these incentives will improve access to HCBS. That is not enough. There must be clear requirements spelled out for plans to ensure that access to HCBS is improved. Plans should be required to ensure that LTSS expenditures, as a percentage of total expenditures on dual eligibles, remain at or above the current percentage and that community LTSS expenditures, as a percentage of total LTSS expenditures, remain at or above the current percentage.
NSCLC	12	7	Prevention	Again, theories about incentives are not good enough. Standards must be created.
NSCLC	13	7	Enhanced quality and monitoring	Which incentives will focus on performance outcomes? When will the quality measures and evaluation process be ready?
NSCLC	14	7	Lessons learned from three transitions	This is not comforting. The transitions we are most familiar with - SPD and CBAS - have not gone smoothly. The planning for the CBAS transition cannot be described as careful, collaborative or transparent. It was the result of litigation that stopped the state from terminating services and has been contentious, rushed and confusing to beneficiaries and providers.
NSCLC	15	7	SOC	Many IHSS recipients meet their SOC each month.
NSCLC	16	8	PACE	As described in our letter comments, we are extremely worried about the impact passive enrollment will have on PACE - the country's most successful model for integrating care for duals. Converting PACE into a subcontractor of manage care plans will change the nature of the program harming an effective, model program.
NSCLC	17	8	D-SNP	How many dual eligibles are enrolled in D-SNPs in each county? In the four demo counties how many are enrolled in the selected plans? Other plans? Which ones? The D-SNP policy the Department released after this proposal is extremely confusing and does not bring us closer to a more integrated, coordinated delivery system. It will be nearly impossible to explain to beneficiaries and community based organizations.
NSCLC	18	9	Rigorous selection process	See comment 2 and our letter comments. We note again that the D-SNP experience of many of the selected plans is quite limited. In LA County, the plans are serving, combined, just 2% of all duals in the county. In San Diego County, the plans are serving combined about 8% of all duals in the County, but no one plan is serving more than 2,500 duals. And for many of the plans, the experience serving dual eligibles has been accompanied by poor quality ratings.
NSCLC	19	10	Geographic service area	Two of the counties listed (Contra Costa and Sacramento) did not have enough plans respond to meet the requirements of the RFS. It is hard to imagine how the demonstration could be implemented in those counties without adjusting the RFS or forcing additional plans to apply in those counties. The local stakeholder support and process in these counties varied significantly. DHCS does not appear to have set any benchmarks for what would qualify as local support and process. We oppose the expansion of the demonstration into any more than 4 counties. See our letter comments for more detail.
NSCLC	20	10	Enrollment process	See comment 4 and our letter comments.
NSCLC	21	10	Sufficient volume	DHCS and plans continue to fail to indicate what would consistent sufficient volume. If all dual eligibles did enroll into the plans selected the number of dual eligibles each of them serve would skyrocket. If half of all dual eligibles in LA County joined LA Care the number of duals to whom they are providing Medicare benefits would be 65 times larger than it is now (2,860 growing to 186,970). Is that what is meant be sufficient volume?
NSCLC	22	11	Contracting with local advocacy organizations	This should not be allowed. Plans should be required to provide support for beneficiary outreach and assistance, but not through direct contracting relationships with local organizations and providers. Assistance provided to beneficiaries must be funded but it must also be conflict of interest free. See our letter comments for more.
NSCLC	23	11	Networks	Just 8 months from implementation, the proposal should be much more specific about what the network adequacy standards should be. In the CBAS experience the state has refused to impose specific network adequacy standards on managed care plans. Plans should be required to sign agreements with existing HCBS providers to ensure continued provision of those services. The proposal says the state will monitor provider networks, but we think it is essential that Medicare play a role in determining whether duals enrolled in the demos have sufficient access to Medicare providers. The section on monitoring network adequacy provides no definition of how 'sufficient' will be defined.

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NSCLC	24	11	Readiness Review	Again, the proposal lacks details that should now be available. What will the readiness review be? Who will do it? When will it be done?
NSCLC	25	11	ADA obligation	The language should say "advised of *and comply with*." We applaud the required use of the facility site review and encourage plans to be required to work with groups like DREDF to prepare for serving individuals with disabilities.
NSCLC	26	11	Geographic analysis, cultural competency and non-medical providers	All plans should be required to describe this analysis. The Department should also conduct an analysis to confirm that the plans' analysis are correct.
NSCLC	27	11	Provider education and model of care	All plans should be required to educate providers on their model of care. They must also be required to explain how they will ensure that providers buy in to their model.
NSCLC	28	12	Value-added supplemental benefits	These benefits must be guaranteed as a benefit to dual eligibles if they are being passively locked into these plans. The plans must provide a more robust benefit package.
NSCLC	29	13	Relationships with CBO's	Plans should be required to contract with the organizations listed.
NSCLC	30	13	Medical necessity standards	This language is confusing. This section should make clear that current medical necessity standards will apply as a 'floor." Plans will not be able to limit availability of services using more restrictive medical necessity criteria than exist in the programs today. Plans will, however, be allowed to provide services that would not be available under current medical necessity criteria.
NSCLC	31	13	Person-centered care coordination	Much more detail is needed in this section. How will the state define person-centered? What will the care coordination standards be? When will they be developed? They must be developed before these programs are allowed to begin.
NSCLC	32	13	Assessments	A uniform assessment tool, process and qualifications/training requirements for people administering the tool must be developed before implementation of the demo begins - not in 2015 as is currently provided by the TBL. Beneficiaries must have access to the tool and it results from the assessment must be appealable. The assessment should be provided by a independent entity that does not have an incentive to under-assess the need for HCBS services.
NSCLC	33	14	ICT	There needs to be much more information provided about how the ICT will do the activities described here. How will DHCS ensure that the care team will be built around the beneficiary and ensure that decisions are made collaboratively? This is an important and welcome program element, but how will it be defined and enforced? Plans should be required to provide enrollees the option of including a LTSS coordinator on their ICT. This is an idea that MA has adopted in their proposal.
NSCLC	34	14-15	Care transitions	This section refers to a transition of care process, but does not define what it is referring to. Have all plans adopted a single process for processing care transitions? What is the screening tool?
NSCLC	35	16	Missing text	The proposal fails to affirm the IHSS purpose of maximum inclusion and integration. See our comment letter for more details.
NSCLC	36	16-17	LTSS Care Coordination	The complexity of the task of integrating LTSS into managed care should be enough to persuade the state to limit the demonstration to no more than four counties.
NSCLC	37	16-17	Rebalancing	We support the emphasis on HCBS and rebalancing. We are worried, however, that the state's proposal rests too heavily on the untested assumption that capitated managed care plans will be incentivized to provide more HCBS. Stronger protections are needed to ensure that this will be the case. Opportunities to stop and evaluate the demonstration before expanding statewide are needed so that the course can be created if the incentives develop differently than anticipated.
NSCLC	38	17	The CCI would require dual eligibles to enroll in Medi-Cal managed care to receive LTSS	We oppose the mandatory enrollment of dual eligibles into Medi-Cal managed care. See our comment letter for more details.
NSCLC	39	17	County social services will continue to perform current IHSS functions…in accordance with existing statutory provisions.	We support the use of current IHSS processes and the preservation of exiting consumer protections. More explanation is needed about how care coordination teams will be established and what role the consumer will play in the development of the team and how the role and activities of the team are defined.
NSCLC	40	17	Universal assessment process	We support the development of a uniform assessment process, but waiting until year three of the demonstration to use the tool is not sufficient. The tool should be developed before the demonstration is implemented. It is also unclear how this assessment process will interact with the health risk assessment discussed at pages 13 and 14
NSCLC	41	18	Managed FFS models	We support the development of a managed FFS model.
NSCLC	42	18	Strong foundation for integrated services	We disagree. The non-COHS plans are just now learning how to provide medical services to seniors and person with disabilities. The demonstration introduces two much more complicated tasks - integrating Medicare services and providers and integrating LTSS. The health plans have very limited experience with these tasks. Delaying implementation of the demonstration and beginning the demonstration as a voluntary program, will provide plans the time they need to learn how to provide the full array of services to this medically complex and diverse population.
NSCLC	43	19	Incorporating SPD lessons	We have yet to see any policy proposals that reflect the lessons the Department has learned from the SPD process. Instead, the policy in this proposal moves faster while providing fewer rights to beneficiaries.

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NSCLC	44	19	Medi-Cal managed care health plans will have had many months to adapt to the unique needs of the SPD population and to adjust their networks accordingly.	It is important to note that they have not had to adjust their networks to include Medicare or LTSS providers since they are not responsible for providing those services to the SPD population. To the extent plans have made adjustments as indicated, these should become requirements, not optional adjustments.
NSCLC	45	20	Waiver programs	This is another area where more detail is needed to evaluate the state's proposal. The intent to provide greater access to waiver like services is a good one that has broad stakeholder support. But more information is needed to understand what will happen to current waiver programs and how slots and funding for services will be allocated. We appreciate that the proposal promises to engage stakeholders in figuring out these details, but doing so will take more time than is currently allocated.
NSCLC	46	21	By the second year of the demonstration, MSSP and managed care plans' care management will be fully integrated. By the third year of the Demonstration, MSSP will cease to exist as a separate, independent program from the plans' care management operation.	We disagree with this approach. The MSSP program is a model for the type of care coordination and integrated service delivery that the demonstration is deigned to advance. MSSP has a tremendous track record of providing needed case management to keep nursing facility eligibles persons in the community. The MSSP program should be preserved and built upon, not dismantled and replaced by medically oriented managed care plans. Plans should be required to contract with MSSP or provide services to high need individuals.
NSCLC		21	CBAS is a benefit offered by managed care plans.	CBS will be a managed care plan benefit, but is not yet. Stating otherwise implies that plans have more experience providing LTSS than they do.
NSCLC	47	21	Plans models of care will include eligibility, protocols and guidelines on utilizing CBAS.	Plans will be required to follow the processes for assessing need for CBAS found in the Darling v. Douglass settlement agreement.
NSCLC	48	22	Stakeholder process	The Department has done a good job sharing drafts and final versions of documents with stakeholders. The Department should continue to maintain the dedicated website and should continue to post relevant documents there. Going forward, MOU and plan contract negotiations must be conducted in a transparent manner.
NSCLC	49	24	Beneficiary protections	We appreciate the Department's continued emphasis on consumer protections in this and other documents. We believe, however, that additional, stronger consumer protections are necessary, starting with the right to voluntarily enroll and disenroll from the demonstrations at any time.
NSCLC	50	25	Self Direction	We appreciate the attempt to preserve these important protections, but more information is needed on how the Department plans to make these rules enforceable.
NSCLC		25	Notification about Enrollment Process	We admire the state's intent to develop a through outreach, education and notice campaign, but there is not enough time to plan and implement a successful strategy before January 1, 2013. Any process which is just now being planned will not be ready by then. At this point, the process will have far less time than the recent SPD process or the 2006 Part D process - both of which had significant problems. Unfortunately, this transition is even more significant and complicated than either of those.
NSCLC	51	25	Contingent upon available private or public dollars other than moneys from the General Fund, contract with community based…	This demonstration should not go forward unless and until a stable, ongoing source of funding is identified and dedicated to providing independent choice counseling for dual eligible beneficiaries, who will be required to make some very complex decisions concerning whether to participate in the demonstration. The state must also provide funding for a dedicated, independent ombudsman who will be able to track and report problems while helping to develop solutions. The Ombudsman program function should be part of an existing advocacy organization with experience serving dual eligibles.
NSCLC	52	25	At least 90 days prior to enrollment…	The notices also need to include information about plan benefits, networks and other features if beneficiaries are going to be able to compare plans and make an informed enrollment decision.
NSCLC	53	26	Health Risk Assessment	The assessment process is only a protection if there are clear standards for conducting the assessment that counteract the incentive plans will have to under-assess the needs of enrollees. A uniform assessment tool and process must be in place before the demonstration begins. Quality assurance measures must be in place to ensure that plans are conducting assessments properly. Individuals must have access to their assessment and be able to appeal them.
NSCLC	54	26	Network adequacy and care continuity	The Medi-Cal access standards for LTSS need to be set soon to ensure that plans can meet those standards by January. The proposal should make clear that plans will be required to meet Medicare network access standards for medical services and prescription drugs.

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NSCLC	55	26-27	Care continuity	These care continuity provisions are not strong enough. We are seeing in the SPD and CBAS transitions that many providers are not willing to accept payment from the plan. This makes the care continuity provisions found here meaningless. The best approach to care continuity is a voluntary enrollment process. If enrollment is mandated or locked in any way, a Medical Exemption Process must also exist.
NSCLC	56	27	Appeals	This process must be developed before the demonstration goes live. Aid paid pending must be available for all services covered under the demonstration. Individuals must retain the right to go straight to a straight fair hearing - they should not be required to endure multiple internal appeals before getting to an independent decision-maker.
NSCLC	57	27-28	Financing and payment	We have serious concerns with an approach that seeks to guarantee savings in year one of the demonstration. The literature suggests that it will take time for these models to produce savings. Emphasizing the need for immediate savings will put pressure on plans to hold costs down. A short term approach to savings will lead to long term damage to beneficiaries and the system.
NSCLC	58	28	Financing and payment	The proposal does not address what incentives will exist when the cost of keeping someone in the community is higher than it would cost to treat them in an institutional setting.
NSCLC	59	28	Financing and payment	This section should include safeguards to ensure that the portion of LTSS spending does not decrease under the demonstrations. Examples are included in our letter comments.
NSCLC	60		Potential improvement targets	There should be explicit targets related to increased numbers of people receiving IHSS, CBAS, MSSP and waiver services. In addition total IHSS hours and average IHSS per person should increase.
NSCLC	61	31	The State will use a combination of existing resources and additional infrastructure to implement this demonstration.	The state has severe capacity issues that is adversely impacting the ability to effectively design and, we are afraid, oversee this demonstration. We are uncomfortable having this demonstration move forward until the state is able to address the key design issues sufficiently in advance of implementation so all stakeholders know what is being proposed, and what role the various state agencies, the EQRO, consumers and others will have in overseeing and evaluating the demonstration. The severe, ongoing budget crisis in this state is driving premature implementation of this proposal for the wrong reasons and is hindering the development of capacity required to make this demonstration successful. It is clear from this document that the state is resource constrained and is unwilling or unable to invest necessary resources, the most blatant example being the express unwillingness to invest in choice counseling for beneficiaries.
NSCLC	62	31	CDA may expand HICAP counselors for the 2012 Open Enrollment period for the Demonstration counties.	This is an unrealistic suggestion at this point in time. Open enrollment starts in October. The open issues will not be resolved in time to train HICAP counselors for the 2012 open enrollment period, and at this late date HICAP is not going to be able to recruit and train sufficient counselors in the four selected counties. Counselors will need to be adept at explaining not just Medicare options, but Medi-Cal as well. This may be a realistic suggestion for the 2013 open enrollment period, but not for this year.
NSCLC	63	32	Waivers	The proposal should be much more specific about what type of authority is necessary to implement this demonstration and when it will be sought.
NSCLC	64	32	Six month stable enrollment period	We oppose the proposed enrollment process.
NSCLC	65	33	Expansion	We oppose the expansion. The state will not be ready to responsibly implement the demonstration in the four counties currently authorized in 2013. It should not be expanded until the four county demonstrations are successfully implemented and robustly evaluated. It is imperative that the state take a cautious approach to putting vulnerable older adults and persons with disabilities into risk-based managed care plans. The proposed capitated financing arrangement for medical services and LTSS will change incentives, undoubtedly in ways that cannot all be anticipated, particularly with most managed care plans having no experience in administering LTSS. These demonstrations need to be subjected to careful evaluation prior to an expansion as proposed in this document.
PhRMA	1	3	Total Number of Beneficiaries Eligible for Demonstration: 800,000	PhRMA is very concerned about California's proposal to incorporate 800,000 dual eligible beneficiaries into the State's yet-to-be-established duals demonstration by next year. First, enrolling so many beneficiaries in managed care plans with little experience in managing the complex needs of this population creates significant risks for beneficiaries. Second, the demonstration will be difficult to evaluate, as there would seem to be an insufficient comparison population. Third, in the event that the demonstration fails to meet the needs of this extremely vulnerable population, it will be very difficult to reverse course without further disrupting patient care relationships. Finally, removing so many duals from stand-alone Part D plans risks raising premiums and undermining access to affordable drug coverage for the State's other Medicare population. A better option would be to proceed with the four counties as a demonstration before taking on the entire dual eligible population.

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PhRMA	2	3	The State will work closely with CMS to provide strong monitoring and oversight of health plans and to evaluate the demonstration's impacts on changes in quality and satisfaction, service utilization patterns, and costs.	We believe that it will be very difficult to effectively evaluate the demonstration's impact, given that the vast majority of the State's dual eligible population will be moved to the demonstration plans in 2013, leaving essentially no comparison population. California should treat the demonstration as an experimental initiative that can provide meaningful insight into the best ways to integrate care for dual eligibles, rather than as a permanent program change. As currently proposed, the size of the California demonstration, which would enroll almost three-fourths of the dual eligibles in the state, as well as the absence of detail regarding a rigorous evaluation plan, are inconsistent with a well-designed demonstration that can provide useful information to policymakers. A better option would be to proceed with the four counties as a demonstration, to identify problems and create solutions, before taking on the entire dual eligible population.
PhRMA	3	10	The State will use a unified, passive enrollment process through which dual eligible beneficiaries who do not make an affirmative choice to opt out will be automatically enrolled in a demonstration health plan. Enrollment will be implemented on a phased-in basis throughout 2013.	Dual eligibles have complex medical needs and often have longstanding relationships with doctors who have prior knowledge of their medical history. In addition, these beneficiaries may have spent years putting together a group of providers that accept their current coverage. Automatically moving these individuals to demonstration plans if they fail to respond to the opt out notice risks disrupting these relationships and thereby compromising continuity of care. As such, PhRMA recommends that, at least initially, patients be given the choice of whether to enroll in the demonstration--following sufficient education and consultation with their providers--rather than being automatically removed from their current care system. We believe that this is particularly important if beneficiaries will be locked into demonstration plans for the first six months. Further, beneficiaries who have affirmatively enrolled in a Medicare Advantage plan or who are currently paying a premium in Part D as the result of a deliberate selection of enhanced coverage should be allowed to keep their current coverage. It is not necessary to override these beneficiaries' choices to test a new model of integrated care. Finally, for beneficiaries who are passively enrolled, it is crucial that the State adopt strong measures to ensure a smooth transition and to minimize the potential for disruptions in patient care, including the use of clinical and medical evaluations to determine an appropriate level and types of service to best serve the needs of the beneficiary, as well as a process to ensure that beneficiaries receive appropriate counseling and education regarding their options and the consequences of enrolling in the demonstration. We also urge California to implement additional safeguards to allow beneficiaries to more promptly opt-out of the demonstration to go back to their original Medicare and Medicaid coverage if the demonstration plan is not working properly for them.
PhRMA	4	11	The State will monitor the adequacy of provider networks of the health plans. If the State determines that a health plan does not have sufficient primary care providers and long-term services and supports to meet the needs of its members, the State will suspend new enrollment of dual eligible beneficiaries into that plan.	While PhRMA strongly supports California's efforts to ensure network adequacy under the demonstration, the proposal does not specify the applicable standards for determining network adequacy. Thus, we urge the State to revise the demonstration to require plans, in accordance with CMS guidance, to meet Medicare network adequacy standards, unless the State's network adequacy standards are more protective. In addition, the proposal does not specify what remedy the plan's existing beneficiaries will have if the plan's network is found to be inadequate. California should revise its proposal to clarify that the plan's existing enrollees will be given the option to leave the plan under such circumstances, even if the determination of network inadequacy occurs during the proposed six-month lock-in period. Finally, the proposal does not specify the need for an adequate number of pharmacy providers, including retail community pharmacies. California should revise its proposal to make clear that demonstration plans must meet Medicare Part D's network adequancy standards with respect to pharmacies, per CMS guidance.
PhRMA	5	25	Properly informing beneficiaries about enrollment rights and options will be an essential component of the demonstration, to allow beneficiaries to be educated about plan benefits, rules, and care plan elements with sufficient time to make informed choices.	PhRMA strongly believes that educating beneficiaries regarding their enrollment rights and options is an essential aspect of the duals demonstration. We urge California to exercise special care in educating beneficiaries about enrollment rights and to respect the choices of beneficiaries who have made an affirmative choice to elect a Medicare Advantage plan or Part D plan that requires a premium payment.

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PhRMA	6	27	Beneficiaries will have access to out-of-network Medi-Cal providers, for up to 12 months, for new members enrolled under the demonstration who have an ongoing relationship with a provider if the provider will accept the health plan's rate for the service offered, or applicable Medi-Cal fee-for-service rate, whichever is higher, and the managed care health plan determines that the provider meets applicable professional standards and has no disqualifying quality of care issues.	Maintaining continuity of care and the ability of patients to choose their care providers should be a top priority in the development of the demonstration. As such, we strongly support California's proposal to allow the state's dual eligibles to continue to see their current Medi-Cal providers for up to 12 months after enrolling in the demonstration. We are concerned, however, that beneficiaries may need to continue to see their current care providers beyond this 12 month period. Thus, we urge California to revise its proposal to also provide the opportunity for out-of-network providers to sign Single Case Agreements with demonstration plans to permit them to continue to treat an enrolled dual eligible for as long as necessary.
PhRMA	7	27	During the six-month stable enrollment period for Medicare, a beneficiary may continue receiving services from an out-of-network Medicare provider for primary and specialty care services if all of the following criteria are met: a) the beneficiary demonstrates an existing relationship with the provider prior to enrollment, b) the provider is willing to accept payment from the demonstration site based on the current Medicare fee schedule, and c) the managed care plan would not otherwise exclude the provider from their provider network due to documented quality of care concerns.	PhRMA strongly supports California's efforts to ensure continuity of care for the duals enrolled in the demonstration. We urge California to provide the same twelve-months of access to Medicare providers as is proposed for Medi-Cal providers. Moreover, we are concerned that, as drafted, a beneficiary might be denied continued access to their current Medicare provider if they fail to notify the plan of their relationship with that provider before being passively enrolled in a plan. Perhaps this is not the intended meaning of the text, but to be certain that this demonstration protects existing beneficiary-provider relationships, we urge California to revise this language to clarify that a beneficiary may continue to receive care from an out-of-network provider as long as the beneficiary can establish that this relationship existed prior to enrollment. In addition, similar concerns about interruptions in care arise in connection with drug formulary differences when patients move to a new plan. Patients who are dependent on multiple medications should not have one or more of these switched based on formulary rules without a thorough consideration of the patient's history with the various drugs and how they work together. We urge California to permit refill or renewal of prescriptions for drugs that were prescribed prior to enrollment, without repeating management steps such as prior authorization, for at least the inital 12 months of enrollment in a plan while the new plan of care for the patient is being developed.
PhRMA	8	27	The State will work with CMS and stakeholders to develop a unified state and federal grievance and appeals process for beneficiaries enrolled in the demonstration.	PhRMA strongly supoports California's proposal to provide a uniform process for grievances and appeals under the demonstration. The demonstration proposal should, however, make clear, consistent with CMS guidance, that Part D standards with respect to grievances and appeals are generally to remain unchanged. Given the vulnerability and special needs of the dual eligible population in particular, it is essential that the State adopt a simple and easily navigable process for grievances and appeals, and that the public be given the opportunity to comment on the details of this process. For this reason, we encourage California to revise the demonstration to provide greater detail regarding the applicable processes for grievances and appeals.
PhRMA	9	29	California will finalize the performance measures it will use to monitor quality and cost in the demonstration only after significant input from multiple stakeholders.	We strongly recommend that California consider adding several quality measures related to medication reconciliation and discharge counseling given the focus of this demonstration on care coordination and the relatively higher rates of hospitalization in the duals population. Medication reconciliation and counseling about medications at hospital discharge represent particularly good opportunities to reduce readmission rates and to improve the standard of care. In addition, medication reconciliation measures can also help avoid contraindicated medication use, reduce medication errors, and ensure appropriate use of medications. We also suggest that California consider adding a quality measure related to medication management for depression, which is a common co-morbidity in the Medicare population, and is often associated with declining function, reduced social networks, and social isolation.

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PhRMA	10	49	Applicant has experience operating a Medicare D-SNP in the county in which it is applying in the last three years. Applicant has not operated a D-SNP in the county in which it is applying last three years but agrees to work in good faith to meet all D-SNP requirements by 2014. Applicant will work in good faith to subcontract with other plans that currently offer D-SNPs to ensure continuity of care.	It is important that the prescription drug benefit for duals in the demonstration to be provided by Medicare Part D plans, and to meet all Part D beneficiary protections, consistent with CMS guidance. This is important not only because the Part D standards have been specifically developed to assure appropriate care for the Medicare population, but also to ensure that the policies that have helped Part D become a cost-effective benefit are available to plans that participate in the demonstration. Outpatient prescription drugs are a Medicare-covered benefit for dual eligible beneficiaries and may not be paid for by Medicaid; California is not permitted to collect a statutory Medicaid rebate on the drugs dispensed to dual eligible beneficiaries. PhRMA urges the State to set out clear rules for every plan to maintain separate prescription drug claims data for the dual eligible population from the Medicaid-only. Moreover, California should ensure that Part D beneficiaries are in a "Part D plan"—via subcontracting arrangements or otherwise—so that any rebates and discounts negotiated with drug manufacturers are exempted from the Best Price provisions of the Medicaid drug rebate statute. Under federal law, the rebates between manufacturers and Part D plans and MA-PD plans for Part D drugs are exempted from the best price calculation and the policy of that exemption should be continued.
Western Center on Poverty and Law	1	7	Target population	This proposal attempts to implement a demonstration in 10 of California's most populous counties by enrolling 73 percent of the Dual population the first year alone. This volume will not provide the state with adequate time to reflect and evaluate the merits or problems with the transition. We ask that the number of sites selected remain at 4, in keeping with SB 208.
Western Center on Poverty and Law	2	10	Geographic Service Area	The 10 counties chosen represent too high a number for the state to oversee in a demonstration. Los Angeles alone represents a full third of the population to be transferred. We ask that a smaller service area be maintained in keeping with the original 4-county pilot set forth in SB 208 and that Los Angeles not be in that group.
Western Center on Poverty and Law	3	10	Enrollment process	We agree that enrollment in the demonstration should be optional. However, an opt-in enrollment process will better accomplish the goals of improved continuity of care , informed choice, and consumer education than passive enrollment.
Western Center on Poverty and Law	4	10	Enrollment process	This proposal calls for mandatory enrollment in managed care for the Medi-Cal portion of a beneficiary's LTSS and wrap-around services. We maintain that beneficiaries should have a choice in their care delivery, that enrollment be opt-in, and that strong Medical Exemption Request and Continuity of Care processes are in place so beneficiaries can maintain Fee For Service, if the beneficiary chooses so.
Western Center on Poverty and Law	5	10	Stable Enrollment Period	Though this proposal states that beneficiaries can continue to see their out-of-network Medicare provider, this is still in effect a 6-month lock-in, to which we object.
Western Center on Poverty and Law	6	10	Stable Enrollment Period	Medi-Cal portions of the benefit should also be subject to opting out of the demonstration at any time.
Western Center on Poverty and Law	6	11	Stable Enrollment Period	Enrollment processes, due process, and continuity of care protections must be spelled out and codified prior to federal or Legislative approval.
Western Center on Poverty and Law	7	11	Stable Enrollment Period	Health plans should be required to contract and partner with local HICAPs and Health Consumer Centers for all steps in the enrollment and utilization process. Several health consumer centers have signed on to letters of support to their respective county proposals and should be brought in as consumer advocacy centers.
Western Center on Poverty and Law	8	11	Provider Networks	We appreciate the clause indicating stoppage of new enrollment into a plan if that plan does not have an adequate number of providers. We also ask that beneficiaries who were already enrolled in plans that are no longer considered adequate be given access to and education on changing plans should their current plan not meet network adequacy standards.
Western Center on Poverty and Law	9	12	Benefit Design and Supplemental Benefits	We are glad to hear demonstration plans are eager to offer benefits included in most Part C plans. We also believe that given the possible confusion beneficiaries will face in this process, that the state's Consumer Assistance Programs be considered as part of the wrap-around services for advocacy and case management.

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Western Center on Poverty and Law	10	13	Care coordination standards	An ongoing stakeholder process is critical to any success in changing care delivery systems for the Duals population. Halfway through 2012, the state has still not developed standards to impart upon and by which to assess participating health plans, making the Department's pronouncements of a smooth transition by January 1, 2013 audacious.
Western Center on Poverty and Law	11	14	Comprehensive health risk assessments and care planning	The state contends it has learned lessons based on the recent transition of seniors and persons with disabilities (SPDs) from fee for service to managed care plans. Health-wise, this is a similar population to Dual-eligible beneficiaries. The transition of SPDs has been fraught with problems that have directly affected the health of an extremely vulnerable population. Very basic consumer protections, such as Medical Exemption Requests (MERs) and Continuity of Care protections have regularly been ignored or inconsistently interpreted. In the abbreviated amount of time California has to develop a proposal for the Duals, including amending those consumer protections to fit Medicare and Medi-Cal, it is highly unlikely that that state will have the standards and procedures in place to perform effective assessments, as well as the protections consumers need when changing their care delivery methods. This underscores the problem with the state's failure thus far to develop standards for the participating health plans.
Western Center on Poverty and Law	12	16-17	LTSS Care Coordination	The vast scope of the Duals transition, just in the original four counties specified, coupled with the task of incorporating LTSS into a managed care benefit mitigates heavily against the state embarking on adding additional demonstration sites. This is a huge task with which the state is faced, and numerous questions as to incorporating LTSS into managed care remain unanswered or unknown.
Western Center on Poverty and Law	13	18	Context within Current State Initiatives - SPDs	If the State is going to use its experience with the SPD transition as a guide, the only logical direction it should go with respect to the Duals transition is to extend significantly the timelines the it has set out, maintain the program at 4 counties not including Los Angeles, and develop rigorous standards which must be met by state departments and health plans prior to transitioning even 1 beneficiary. DHCS references a survey that indicates of the 5000 SPDs they called, and the 463 that responded, approximately 403 were satisfied with their care. This is out of a total transition population of over 365,000. Such a small sample size cannot serve as the foundation for moving forward at an unrealistic pace. A realistic timeline for a servicable number of demonstration sites is necessary. This includes significantly enhanced beneficiary outreach and education, as more than 70 percent of SPDs were defaulted into health plans they did not choose according to the State's own data, better provider education that includes the use of stakeholders in writing provider bulletins, codified continuity of care provisions, and the ability for ALL beneficiaries to opt into the program, whether it be for their Medi-Cal or Medicare share of the benefits. SPDs saw significant delays in care, including for beneficiaries on dialysis, those with enhanced psychological disorders who needed anti-psychotic medications, and persons scheduled for surgeries. The list goes on. DHCS contends that only a small number of medical exemption requests were made, without considering that those tend to be made by beneficiaries with significant health problems. Moreover, stakeholders continue to see the inconsistent application of standards for Medical Exemption Requests. Until DHCS can demonstrate that every SPD has been smoothly transitioned and are in plans that meet their needs, the transfer of additional Dual beneficiaries is premature and irresponsible and would be at odds with the project goals set forth in SB 208, especially the goal of improving continuity of care.
Western Center on Poverty and Law	14	22	Design Phase Stakeholder Engagement	Though we appreciate the stakeholder process as it has developed over the past 12 months, we must assert that it has been too large for significant substantive engagement. Only in the past month have the smaller working groups met, which are theoretically responsible for developing actual concrete consumer protections. Considering the state has proposed a January 1, 2013 start date, the preceding stakeholder engagement has been insufficient and seems to have significantly favored health plans, who started with and have been given greater access to information about the proposal, over beneficiaries or consumer advocates.
Western Center on Poverty and Law	15	24	Ongoing Stakeholder Feedback	The workgroups developed have only met twice in the last two months. This is a good start to the process, but far too abbreviated for a January 2013 start date.
Western Center on Poverty and Law	16	25	Beneficiary protections: Self-direction	The state and contracting health plans must honor continuity of care plans and obligations. If beneficiaries are truly directing their own care, they will be choosing their providers. Given the problems with SPDs' choice of provider being honored with fee for service providers, the protections proposed for the Duals transition must be codified.

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Western Center on Poverty and Law	17	25	Beneficiary protections: Notification	Beneficiaries should be given a choice to participate in the demonstration, and this includes an opting in process. Beneficiaries and advocates must be involved in the writing and assessment of outreach and education materials to beneficiaries and providers. The state must publicize the Medi-Cal ombudsman and provide contact information for HICAPs and Health Consumer Centers in large-print, in an easy-to-find place on enrollment materials. Easy-to-understand information on grievances and appeals, or more generally problems and issues, must be included in enrollment materials. Managed care plans must have a unit dedicated to smooth transitions with ongoing referrals and connections to HICAPs or Health Consumer Centers should a beneficiary need additional assistance. A 90-day notice must provide instructions for opting out of the demonstration, on either the Medi-Cal or Medicare portion, or both.
Western Center on Poverty and Law	18	26	Beneficiary protections: Network Adequacy	The demonstration clearly cannot go forward until these standards are developed, communicated to plans and other stakeholder, and operationalized through contracts or other processes. Another reason to delay the implementation.
Western Center on Poverty and Law	19	26-27	Beneficiary protections: Care continuity	The state has noted that existing continuity of care requirements will be required of participating health plans. Additional oversight is required, as existing continunity of care laws and basic Medical Exemption Requests have been routinely denied, or are facing backlogs for approval. Additional state oversight, perhaps via state legislation, is necessary.
Western Center on Poverty and Law	20	27	Beneficiary protections: Care continuity	This states that beneficiaries will have access to out-of-network Medi-Cal providers for up to 12 months if the beneficiary can demonstrate a relationship with the provider and if the provider accepts the health plan's rate or the fee for service rate. Additional language needs to be provided that ensures additional criteria are not applied in the processing of the request, as arbitrary standards were applied in the SPD process. This cannot happen again.
Western Center on Poverty and Law	21	27	Beneficiary protections: Care continuity	The same applies as in comment #20.
Western Center on Poverty and Law	22	27	Beneficiary protections: Appeals and grievances	Many advocates are satisfied with the existing Medi-Cal appeals and grievance process. Combining it with the Medicare appeals process could well compromise protections and processes that have stood for years in California, and that are well-understood by Administrative Law Judges and attorneys. A promise that the state will work with CMS to develop a unified process conjures a daunting process at best, and provides an additional reason, 7 months prior to the state's proposed implementation date, that the Duals proposal be given additional time for planning.
Western Center on Poverty and Law	23	28	State's Ability to Monitor, Collect and Track Data on Quality and Cost	Data must be provided on a monthly and ongoing basis and be distributed publicly, via internet and other communications systems. These data must include the number of MERs and Continuity of Care requests and the disposition or outcome of each request. These data must drive the enrollment or the stoppage of enrollment should certain benchmarks not be met. In addition to MERs and COCs, network and provider adequacy, health plan benchmark data, and state response times must be provided as well.
Western Center on Poverty and Law	24	29	Potential Improvement Targets	Clinically-driven outcomes are important, and so are self-assessments of health status. We ask that beneficiary-reported health outcomes on their own assessment of their health be included, as this is meant to be a demonstration model.
Western Center on Poverty and Law	25	29	Potential Improvement Targets	The state will require that demonstration sites be accountable for provider performance within their systems. The state, then, must be accountable for plan performance. The Department of Managed Health Care must be adequately funded and staffed to ensure plan compliance, as recent state audits have indicated severe problems in two-plan counties in terms of fiscal solvency and beneficiary access to care.
Western Center on Poverty and Law	26	31	State Infrastructure/Capacity	We are sincerely concerned with the capacity of DHCS and partners to adquately implement the entire proposal. As evidenced through the SPD transition, and in coordination with additional state budget proposals that ask for the wholesale change of health care delivery systems, piling on the needs and care of a vulnerable population should require a thorough assessment of the readiness of the Departments to engage. Only in January 2012 did the Department of Managed Health Care come under the same agency umbrella as DHCS, and the departments are still developing communications and coordinating functions that did not exist just a few months ago.
Western Center on Poverty and Law	27	32	Six-Month Stable Enrollment Period	This is essentially a six-month lock-in, which is antithetical to beneficiary choice in how they receive their health care. We have previously opposed this type of proposal as components of budget proposals.

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Western Center on Poverty and Law	28	33	Expansion Plans	There are no mechanisms built into the timeline to pause this transition to ensure that beneficiaries' needs are met, that they are receiving the care they were promised, and that plans are performing up to standard. This proposal to move from a demonstration to statewide implementation over 3 years is premature. SB 208 requires the department "to conduct an evaluation to assess outcomes and the experience of dual eligibles. . . and provide a report to the Legislature" after the first year and annually thereafter. (See W & I Code Section 14132.275, subsec. (k).) To give this evaluative requirement meaning, the program should not expand unless and until the evaluation process (which SB 208 requires stakeholders to help devise) reveals that the state is ready to expand in a way that does not harm the beneficiaries.
California associaation of Health Facilities	1	3	Table 1 , List of Counties	CAHF recommends that DHCS limit the pilot counties to San Mateo, Orange and San Diego the first year. We are concerned that DHCS is moving too quickly and the health plans will not be ready to the detriment of beneficiaries, similar to the SPD challenges and implementation of Medicare Part D.
California associaation of Health Facilities	2	5	20 % of dual eligibles beneficiaries are enrolled in any type of organized health system.	All of the selected counties operate or have operated D-SNPs and beneficiaries have had the option to voluntarily enroll in these programs. The fact that statewide participation is so low should be an indicator that beneficiaries prefer to remain in the Medicare fee-for-service system in most counties. An exception is San Mateo county, where 62% of the county's duals enrolled in their D-SNP, which indicates a preference on the part of beneficiaries. DHCS should consider extensive outreach to encourage voluntary enrollment and eliminate passive enrollment.
California associaation of Health Facilities	3	7	Lessons Learned	The document refers to recent lessons learned, but fails to mention the challenges that faced dual eligible beneficiaries when 1 million beneficiaries were enrolled into Medicare Part D at one time. The challenges were documented by testimony to the legislature in 2006. Beneficiaries were unable to obtain critical medications and the system failed, overwhelmed with phone calls to health plans, Medi-Cal, Medicare and HICAP. CAHF is concerned that the state will not be able to assist over 800,000 duals eligibles that will be enrolled in Medi-Cal managed care plans on January 1, 2013, to access medically necessary services in a timely manner because of similar communication challenges.
California associaation of Health Facilities	4	7	Share of Cost Beneficiaries	If DHCS is going to include beneficiaries with SOC that reside in nursing facilities in the demonstration, health plans should be responsible for collection of SOC. CAHF has proposed trailer bill language relating to this issue. As to the issue of excluding non-institutionalized beneficiaries from the demonstration, DHCS should clarify their intent to exclude them from mandatory enrollment in the health plan for Medi-Cal, Medicare, or both. Their intent is unclear.
California associaation of Health Facilities	5	8	Developmentally Disabled (DD) Beneficiaries	CAHF recommends that DHCS exclude individuals residing in DD facilities from the demonstration waiver for both Medi-Cal and Medicare services. We appreciate that DHCS proposes to exclude Medi-Cal payments to DD facilities from the demonstration; however, requiring these beneficiaries to enroll in the demonstration pilots for both their Medicare and Medi-Cal services is not acceptable. In April 2011, health plans expressed reservations about the adequacy of their provider networks to care for these very fragile and medically complex beneficiaries. Subsequently, DHCS made the policy decision to exclude them from mandatory enrollment of SPDs. CAHF is concerned that the health plans continue to lack expertise in this area and are not prepared for the challenges of caring for this population. DD facilities and their residents have developed close relationships with primary care physicians and medical specialists who have experience and a dedicated interest in providing care to this population. DD facility regulations require physician exams of residents no less than every 60 days, so DD residents already have access to physician services, including preventive care, which reduces hospitalizations and emergency room visits. These medical exams generally occur in the clients' homes (DD facility) because physical, cognitive, and behavioral challenges make it extremely difficult to accommodate their needs in a traditional medical office setting. If DHCS continues to require mandatory enrollment in the health plans, the health plan contracts should explicitly address the availability and mandatory payment of physician exams in the facility. Also, CAHF is concerned about the potential for duplicative and conflicting case management services that will be provided by the DD facility, the attending physicians, the health plan, and Regional Centers.
California associaation of Health Facilities	6	10	Geographic Service Areas	See comment 1.
California associaation of Health Facilities	7	10	Passive Enrollment	See comment 2.

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California associaation of Health Facilities	8	10	Stable enrollment period (Lock-in)	The stable enrollment period is a concern. People should should have the freedom to decide if they want to stay in a managed plan and not held hostage for six months. CAHF supports DHCS' proposal to allow continued access to out-of-network providers during the six-month lock-in period since this assures continuity of access to care. However, given the lessons learned from the challenges faced by SPD beneficiaries and providers, health plans should have the ability to market and provide services smoothly from the first day of enrollment. If they cannot do so, then people should have the choice if they are not happy with the health plan. The fact that DHCS is proposing a six-month stable enrollment period implies a lack of confidence that the health plans will be able to market their services effectively and establish relationships from the very beginning of enrollment. As part of the readiness to implement, health plans should be expected to demonstrate a smooth transition to managed care and continued access to care without a stable enrollment period.
California associaation of Health Facilities	9	13	Medi-Cal and Medicare medical necessity standards will not be restricted by health plans.	Based on implementation of mandatory enrollment of SPDs, CAHF is concerned that health plans will continue to fail to recognize the difference between services provided in skilled nursing facilities for Medicare Part A and Medi-Cal. A reference should added to assure that participants have continued access to skilled nursing facility services as provided in the Medicare Benefits Policy Manual, Chapter 8 and the DHCS Manual of Criteria. DHCS should include these references in the health plan contracts.
California associaation of Health Facilities	10	16 & 19	Behavioral Health Care Coordination and County Specialty MH Services and Substance Abuse	CAHF agrees that close collaboration between the health plans and county agencies will be necessary to ensure continuity of ongoing treatment modalities of care under specialty mental health plans and substance abuse. Further, given the current mechanism of funding of these services through the county mental health programs, the capitation carve out is a must have and not an option.
California associaation of Health Facilities	11	Page 20 and 21	HCBS Waiver Programs	CAHF supported DHCS' efforts to assure that people receive the right services at the right time in the appropriate setting. DHCS has stated that existing enrollment caps would be maintained for HCBS waivers; however, DHCS is also considering options for how new enrollment in these waiver would be treated under the demonstration. On page 21, the state is considering elimination of waiver programs and these waiver services would become benefits of the health plans. CAHF is concerned about the lack of oversight for assisted living (AL) facilities. Oversight of AL by the Department of Social Services is minimal when compared to the regulatory oversight imposed by CMS and the State to assure quality services are provided. The diversion of medically complex patients from skilled nursing facilities to AL without adequate safeguards to assure patient safety and access to skilled and rehabilitative services should be addressed by DHCS. Prior to expansion of the AL waiver, DHCS should consider an evaluation of the utilization of services for these beneficiaries and associated health outcomes.
California associaation of Health Facilities	12	25	Self-Direction of Care	An additional bullet should be added to assure that participants are informed that they are entitled to post-acute and continuing care in a skilled nursing facility. CAHF is concerned that participants will not receive effective post acute care, including appropriate access to physical, occupational, and speech therapy, that will allow them to improve their health outcomes, which are necessary to live independently.
California associaation of Health Facilities	13	25	Notification of Enrollment Process	This section addresses enrollment issued relating to Medi-Cal services and should be expanded to explain Medicare enrollment in the health plan and changes for Medicare.
California associaation of Health Facilities	14	26	Health-Risk Assessment	A provision should be added to require that the assessment process assure that participants have the ability to receive the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being.
California associaation of Health Facilities	15	26	Network Adequacy and Care Continuity	DHCS should assure that network adequacy standards under development for long-term services and supports include providing beneficiary access to any willing long-term care provider who is licensed and certified for the Medi-Cal and Medicare programs.

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California associaation of Health Facilities	16	27	Appeals and Grievances	We suggest that the language be amended to include: The managed care health plan shall provide, at a minimum, and in addition to other statutory and contractual requirements, an audit and appeal process for health care providers as follows: (A) Any appeals resulting from audits of claims by managed care health plan will be subject to the provisions of Welfare and Institutions Code Section 14171. Notwithstanding the above, any appeals resulting from audits of Medicare claims will be subject to the limitations on recoupment provided for in Part 405 of Title 42 of the Code of Federal Regulations. (B) Any appeals resulting from any other determination by the managed care health plan will be subject to the provisions of existing state and federal law relating to managed care health plans participating in the Medi-Cal and Medicare programs.
California associaation of Health Facilities	17	27/28	Financing and Payment	Language should be added to require health plans to: pay not less than established Medicare and Medi-Cal reimbursement rates for skilled nursing facility services; promptly pay claims submitted in either a paper or electronic format with 14 days of receipt of the claim; make payments for claims by electronic fund transfer; and pay any crossover payments for Medicare beneficiaries that opt to remain in Medicare fee--for-service.
California associaation of Health Facilities	18	29	Potential Improvement Targets for Performance Measures	The performance measures should be uniformly applied to all health plans. CAHF suggests that DHCS also include the reduction for re-hospitalizations as a performance measure, along with identifying the rates associated with beneficiaries that are receiving HCBS and institutional services. Health outcomes and total expenditures should also be measured for HCBS and institutional care.
California associaation of Health Facilities	19	30	Expected Impact on Medicare and Medi-Cal Costs	Overall patient acuity in skilled nursing facilities would be expected to increase, which will increase the staffing necessary to care for the patients. This will results in increased facility costs.
California associaation of Health Facilities	20	32	Six-Month Stable Enrollment Period	See comment 2.
California associaation of Health Facilities	21	33	Expansion Plans	See comment 1.
California associaation of Health Facilities	22	33	Enrollment	See comments 1 and 2.
Senior Services Coalition of Alameda County	6	8 & 32	regarding PACE	We are glad to see that PACE will be a clear option for enrollment, and that managed care plans will be encouraged to contract with PACE providers to serve plan members who could benefit from PACE services, but we strongly recommend that beneficiaries be able to switch to a PACE plan if they are eligible and desire to do so. This ability to choose to enroll in a PACE plan should be in effect even during the 6-month "lock in" period. In addition, in counties with PACE providers, managed care plans should actively offer PACE as an alternative to nursing home admission for any plan member for whom nursing home admission is imminent.
Senior Services Coalition of Alameda County	7	45	regarding CBAS and ADHC	We strongly recommend that the state require managed care plans to evaluate members for and offer Adult Day Health Care or ADHC-like options to patients who, while not meeting the criteria for CBAS, could nevertheless benefit from the multi-disciplinary care offered at an ADHC/CBAS center or the protective supervision and monitoring offered at an Adult Day Care center, either short term or longer term. For instance, a patient being discharged from hospital to nursing home, or from hospital to home or from nursing home to home who needs significant support or therapy services to either maintain or gain the ability to function independently, could greatly benefit and should be offered ADHC or other daytime care as an option.

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Senior Services Coalition of Alameda County	8	2	"This demonstration aims to enhance the IHSS program's ability to help people avoid unnecessary hospital and nursing home admissions; IHSS will remain an entitlement program and serve as the core home-and community-based service. County social workers will continue determining IHSS hours and the fair hearing process will remain. The principles of consumer-direction and continuity of care will be key aspects of the beneficiary protections."	We strongly believe that the principles fundamental to IHSS will be compromised without local public authorities for IHSS and local consumer advisory bodies. Legislation has recently been proposed in California's Senate that could ultimately shift current responsibilities of public authorities to the State and consolidate public authorities into a single, state-wide agency. Moving public authority services to Sacramento would be a tragic disservice to consumers and would undermine the collaborative ability of local stakeholders. We recommend that strong language be added to this Demonstration Plan that maintains the role of public authorities in each county in local planning; consumer advocacy; worker screening, training and health coverage; bargaining; and emergency worker replacement services.
Senior Services Coalition of Alameda County		19	"Medi-Cal managed care health plans will have had many months to adapt to the unique needs of the SPD population and to adjust their networks accordingly. "	We disagree with this statement. Medi-Cal Managed Care Plans have not had to adjust their networks to include Medicare or LTSS providers since they are not responsbile for providing those services to the SPD population. To the extent plans have made adjustments as indicated, these should become requirements, not optional adjustments.
Healthcare First South LA	1	1	The health plans will be responsible for providing beneficiaries a full continuum of Medicare and Medi-Cal services	Excellent decision. Carve outs lead to fragmentation and impaired ability to coordinate care.
Healthcare First South LA	2	2	California will use a passive enrollment system	This is a great approach because it will move more people into an environment where care can be better coordinated with better outcomes at a lower cost.
Healthcare First South LA	3	3	The demonstration model of care will include person-centered care coordination supported by interdisciplinary teams	This is a good model in that the services and system are built around the person needing services and not the provider of services. Interdisciplinary teams are advisable since it allows the lowest cost, qualified person to assist in each segment of care. The non-physician providers are often the best equipped to help a member.
Healthcare First South LA	4	3	Summary of Covered Benefits: a reference is made to Assisted Living Waiver Services	We support the effort to include Assisted Living as a benefit. While not a typical Medi-Cal benefit, offering it to all duals is a cost-effective alternative to skilled nursing facilities.
Healthcare First South LA	5	3	Summary of Covered Benefits: Includes In-Home Supportive Services (IHSS), Community-Based Adult Services (CBAS), and five waiver services: Multi-Purpose Senior Services Program (MSSP), Nursing Facility/Acute Hospital Waiver Service, HIV/AIDS Waiver Services, Assisted Living Waiver Services, and In-Home Operations Waiver Services.	HFSLA supports the inclusion and integration of all of these benefits that have been shown to keep individuals in their homes as long as possible in a cost-effective manner and avoids or postpones admissions to Skilled Nursing Facilities.

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Healthcare First South LA	6	3	County-administered mental health and substance use services will not be included in the capitation rate, but by 2015 these services will be closely coordinated and potentially integrated at a local level.	Services follow the money. There is tremendous fragmentation and a lack of coordination between physical health services and mental health and substance use services now. The DMH has been integrated into DHCS already. Integrate these services into the capitation rate NOW to decrease fragmentation of services for a high risk population with a lot of Behavioral Health issues. We encourage the evaluation of alternative payment methodologies to incentivize cooperation and collaboration between two delivery systems that currently operate in siloes.
Healthcare First South LA	7	4	Phased-in enrollment process starting January 1, 2013	It will be May before the proposal is submitted to CMS. They will have another 30 day comment period. This leaves less than 6 months for a plan to integrate services, many of which have never been provided by the plan, in 6 months. This is an unrealistic deadline. HFSLA recommends that a date of 7/1/2013 or 1/1/2014 be used.
Healthcare First South LA	8	5	"Medicare and Medi-Cal often work at cross purposes, because no single entity is responsible… Beneficiaries and other families/other caregivers must navigate these separate, complex systems on their own. This often results in fragmented and inefficient care, and sometimes no care at all."	HFSLA agrees with this statement and, as a result, believe it is harmful not to integrate behavioral health and substance use services under the same capitation rate. Our target population has a high incidence of Behavioral Health problems and absent a change in the recommendations for the duals, the current dysfunctional program will persist.
Healthcare First South LA	9	6	"beneficiaries' needs will no longer be overshadowed by opportunities to shift costs to a different payer"	This is only accurate for components of Medicaid. Cost shifting will continue to occur to carved out programs, e.g. Mental Health, Substance Use, CCS, Regional Centers, Dental, CCS, etc. The cost shifting will continue which leads to fragmentation, confusion and higher costs. HFSLA supports incorporating all of these carved out services into a comprehensive delivery system with one responsible entity.
Healthcare First South LA	10	6	"An integrated approach will create financial incentives for greater use of HCBS, such as IHSS"	IHSS has operated in a parallel universe to the health care delivery system. By making it a component of the delivery system, it can be a powerful adjunct to the patient centered medical homes.
Healthcare First South LA	11	7	Share of Cost beneficiaries in Nursing Facilities will be enrolled in the demonstration pilots	Good move. These members look exactly like the other duals.
Healthcare First South LA	12	8	Children under age 18 will not be enrolled in the demonstration.	Need to clarify if children 18-20 that are dual eligibles will be removed from the CCS program and put into the demonstration pilot and if the associated funds will follow.
Healthcare First South LA	13	10 and 11	Enrollment Process	The document is silent about beneficiaries living in counties where there are more than one plan (e.g. Los Angeles and San Diego). If a beneficiary does not choose a plan, will the auto assignment process currently used for the Medi-Cal program be used for those that don't select a plan? This needs to be addressed in writing.
Healthcare First South LA	14	12	"Demonstration health plans are eager to offer additional benefits…Additional benefits include care management interventions, such as specific disease management programs, intensive care management for high-risk populations and care transition services. "	HFSLA supports this concept and believes that such additional services will lead to better outcomes for the vulnerable duals population. We also support the evaluation and implementation of alternative payment methodologies to promote utilization of these programs.
Healthcare First South LA	15	14	Person-centered medical homes and interdisciplinary care teams (ICT) built around the beneficiary	We strongly support this concept to improve care and communication.

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Healthcare First South LA	16	15	Use of technology - Electronic consultation between primary care providers and specialists offers improved collaboration, increases efficiency of specialty care visits, and facilitates resolution of members' unmet needs and issues.	HFSLA strongly supports the prudent use of proven technology to improve care.
Healthcare First South LA	17	16	Eligibility for IHSS and assessment and authorization of qualified hours is and will continue to be determined by county social service agencies.	This is yet another carve out that supports challenging communication between two vastly different agencies (health care and social services) and fragments coordination of care. We recommend that the entity responsible for providing and paying for the service is also responsible for determining hours authorized, just as in all other aspects of managed care.
Healthcare First South LA	18	24	Ongoing Stakeholder Feedback	HFSLA supports the solicitation of feedback during the demonstration period so improvements can constantly be made to the programs.
Healthcare First South LA	19	26	Health-Risk Assessment	HFSLA agrees that this is a great idea for every beneficiary and that reassessments are equally important. We urge that the demonstration requires that this information is available to all providers in a HIPAA compliant fashion. Too often HRAs are a tool used by a single individual. This is knowledge that should be shared widely, but appropriately.
Healthcare First South LA	20	26	"The State will require that health plans: …contract with safety net and traditional providers"	HFSLA agrees that this is an important component to assure that providers that understand the population, their needs and may be more culturally sensitive should be included in any demonstration.
Healthcare First South LA	21	27 and 28	Health Plan Payments and Financial Incentives	Payment to the health plans will be on risk adjusted basis. The Demonstration projects should be compelled to also pay its providers on a risk adjusted basis to assure sufficient funds reach the frontline provider.
Healthcare First South LA	22	28	State will monitor quality and cost OUTCOMES	HFSLA agrees that this is where the monitoring emphasis should lie, and not just focusing on processes.
Healthcare First South LA	23	30	"The current lack of integration fosters cost-shifting and underinvestment"	HFSLA agrees. See comments above about carve-out programs leading to problems. Do not carve out mental health, substance use, regional center services, CCS for children over 18, etc.
Healthcare First South LA	24	32	6 month Stable Enrollment Period	HFSLA agrees that this is a very good idea. Longer time would be better because it would improve the chances that a member would interface with the system and hopefully have a good experience.
HIV Community	1	N/A	General overview	Dual eligibles with HIV are among the most vulnerable population living because they have had to complete more than a 24 month waiting period after a disability determination to qualify for Medicare and must also meet the income and asset tests to qualify for Medi-Cal. They are most often challenged by multiple co-morbidities as well as complex and advanced HIV disease. They are high dependent on the regular and uninterrupted provision of primary medical care, adherence support, and a complex medication regimen, as well as other essential services that keep them linked to and retained in care. Services for most duals with HIV are already coordinated through a set of benefits from Medi-Cal, Medicare, and Ryan White. It is essential that we take the lessons learned from moving people with HIV into LIHPs and Medi-Cal managed care. Moving dual eligibles into the demonstrations before the plans are ready to serve them and before beneficiary protections are fully articulated and accessible by medical providers, RW case managers and benefits counselors and beneficiaries will result in serious and potentially life-threatening disruptions to care for this vulnerable population.
HIV Community	2	N/A	General overview	We are concerned that the implementation timeline is much too aggressive to successfully integrate this vulnerable population. It is essential that plans are fully ready to serve all dual eligibles, including people with HIV, and that consumer protections and assessment tools are fully articulated, appropriately disseminated to providers, case managers and others giving individual assistance, and clients, prior to enrollment in the demonstration project. Appropriate education and training on transitions and consumer protections prior to enrollment is also necessary.

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HIV Community	3	N/A	General overview	We also believe that the program as articulated is too large and ambitous for the first phase. Los Angeles County is home to 40% of the HIV positive population in California. Incorporation of LA County in the first phase will result in serious disruption in the coordinated care dual eligible beneficiaries with HIV currently receive through Ryan White programs that wrap around their Medi-Cal and Medicare services. Additionally, moving a population the size of the LA dual eligible population is not feasible or reasonable in the articulated timeline.
HIV Community	4	N/A	General overview	Plans must be fully ready to serve dual eligibles with HIV, consumer protections must have been fully vetted, distributed to providers and clients and sufficient training must have been provided prior to any inclusion of people with HIV in the demonstration.
HIV Community	5	8	AIDS Healthcare Foundation (AHF) Enrollees: Similar to PACE, AIDS Healthcare Foundation will remain a separate program, and existing enrollees will not be passively enrolled in the demonstration.	We believe that not only those HIV positive dual eligibles served by AHF but all HIV positive dual eligibles should be carved out of the demonstration. As a vulnerable population with access to Ryan White services that assist in care coordination, people with HIV should not be included in the demonstration until such time as it can be shown that services currently available under Ryan White will also be available in the demonstrations and that the plans have incorporated Ryan White providers who can meet the needs of people with HIV.
HIV Community	6	9	Managed care done well leads to high quality care. The selected plans demonstrate a proven track record of business integrity and high quality service delivery.	Although the state held a rigorous process, the National Senior Citizens Law Center released a report entitled “Assessing the Quality of California’s Dual Eligible Demonstration Health Plan” that raised serious concerns about the 8 health plans chosen by the state to serve low-income older adults and people with disabilities in Los Angeles, Orange, San Diego, and San Mateo counties. Seven of the approved plans received a global health plan rating of only 1 out of 5 stars, where one is the lowest possible rating (ie: poor) and five is the highest possible rating (i.e: excellent). These plans are clearly not ready to serve this vulnerable population, including people living with HIV/AIDS. The state must ensure that all plans included in the demonstration improve the necessary performance metrics to the equivalent of a four star or higher rating prior to enrollment of duals into the plans.
HIV Community	7	10	The State will use a unified, passive enrollment process through which dual eligible beneficiaries who do not make affirmative choice to opt out will be automatically enrolled into a demonstration health plan	We continue to oppose passive enrollment for the dual population, including people with HIV, because it could adversely impact patients’ ongoing access to providers, including specialists, upon whom they have relied for care and treatment for many years. The majority of the HIV-positive duals are currently receiving integrated and comprehensive services, many of which may be tailored to unique psycho-social and medical needs. Dual eligibles must retain the right to opt-in to a coordinated demonstration once they ensure that their essential providers can and will be a part of the new network or acceptable equivalents can be engaged. In addition, the pharmacy benefits must be able to be compared prior to enrollment to ensure continuity of care in medication regimens.
HIV Community	8	10	The Governor's Coordinated Care Initiative...proposed mandatory enrollment in managed care for Medi-Cal benefits. Beneficiaries who opt ou of the demonstration would still be enrolled in managed care for their Medi-Cal only benefits (wrap around services and LTSS). Managed care for dual eligible beneficiaries would only be voluntary for Medicare benefits and services, not Medi-Cal.	We strongly oppose the mandatory enrollment of dual eligibles, including people with HIV, into Medi-Cal managed care for their wrap around services with no mechanism by which a dual eligible can remain in fee-for-service Medi-Cal. Allowing opt-out from Medicare managed care while forcing people into Medi-Cal managed care will create mass confusion and lead to disruption in services. LTSS have not been delivered by managed care in the past and there is no guarantee that the Medi-Cal managed care will be able to contract with experienced LTSS care providers, particularly in HIV care, which is highly specialized to serve a younger population with different and multiple care needs. There is also no evidence that the Medi-Cal managed care plans can meet the needs of this very vulnerable population.
HIV Community	9	10	Under the proposed initiative, once enrolled in a demonstration site, beneficiaries will have another opportunity to opt-out after a six-month stable enrollment period during which the plans must ensure continuity of care.	We oppose a lock-in period for all dual eligibles and in particular for dual eligibles living with HIV/AIDS. As we learned from the movement of seniors and persons with disability into Medi-Cal managed care, the majority of people with HIV/AIDS may not even realize they have been transferred to a managed care system prior to the time when they are able to opt-out. A lock-in period will mean that this vulnerable population could face serious disruptions in care, not only with their provider but as we experienced with the movement of SPDs to managed care, with essential ancillary services such as labs and imaging tests and pharmaceutical benefits. This population, typically at a more advanced disease stage, can't risk disruption without serious individual and public health implications.
HIV Community	10	11	Provider Networks	As we learned from the movement of SPD’s into managed care, network adequacy standards do not meet the needs of people living with HIV/AIDS. It is essential that plans show that they have reached out to all qualified Ryan White providers prior to final development of plan networks. Plans will also need to ensure that HIV providers are clearly identified in the network information prior to implementation.

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HIV Community	11	12	Sites will also be responsible for all Medi-Cal State Plan benefits and services, including long-term institutional, and home- and community based services, including: Other Section 1915 (c) home- and community based services.	We oppose the inclusion of the 1915c Home and Community-Based HIV/ AIDS Waiver Services in the LTSS Care Coordination under managed care. These services have been developed over the last 20 years and are designed to serve the unique needs of people with HIV. HIV/AIDS Waiver providers have a long history of providing stable community-based care for the vulnerable HIV/AIDS population with significant disability. The services are provided by trained RNs, Social Workers, and care providers who have experience dealing with the multitude of co-occurring disorders and issues specific to this population. Most of the "traditional" home care providers, including the other Waiver programs, provide care to elderly patients who have a specific disease process. HIV beneficiaries are younger, can have substance use and mental health challenges, often have complex treatment regimens and associated adherence issues, as well as serious psychosocial issues such as poor nutrition,unstable housing and finances, and legal issues. Additionally, providers must know how to assist with multiple co-morbidities such as, cancer, metabolic diseases, liver/renal diseases, and cardiac/respiratory diseases. Managed care plans are likely ill-equipped to effectively serve the HIV positive population. We urge the state to carve these services out of the demonstration as you have done with home and community based services for adults with developmental disabilities.
HIV Community	12	12	Demonstration health plans are eager to offer additional benefits beyond those currently available in most Medicare Part C benefit plans, such as dental, vision, non-medical transportation, housing assistance, and home -delivered meals. The extent of a health plan's ability to offer value-added supplemental benefits such as these will be better understood during the rate development process. Additional benefits include care management interventions, such as specific disease management programs, intensive care management for high-risk poulations, and care transition services. Other additional benefits could include home modification, access to nutritional counseling, and exercise facilities.	Although the plans may be interested in providing additional benefits such as vision, dental, non-medical transportation, housing assistance and home delivered meals, etc., they are not required to and these services are not necessarily geared toward the special needs of people living with HIV/AIDS. At the same time, people with HIV/AIDS risk losing access to their specialized Ryan White services (which deliver most of the above value added services) due to lack of clarity and specificity of what benefits the plans will offer and Ryan White payer of last resort rules, which require people to use services offered by their primary insurance coverage instead of Ryan White. It is difficult to see what benefit the care coordination project offers dual eligibles living with HIV, who could risk losing continuity of care with their long term HIV experience provider, access to specialized HIV/AIDS LTSS, and access to specialized value added Ryan White services if they are included in the demonstration.
HIV Community	13	12	Benefit design and supplemental benefits	Plans must include the full ADAP formulary, including dosing schedules and utilization management requirements, in order to avoid disruption in the medication regimens people with HIV rely on to achieve optimum health outcomes.
HIV Community	14	17	Under this demonstration, managed care plans will assume responsibility for the provision and payment for all LTSS. Further, the Governor's Coordinated Care Initiative would require dual eligible beneficiaries in the demonstration counties to enroll in Medi-Cal managed care to receive LTSS, regardless of whether they enroll in the demonstration.	We oppose the inclusion of the Home and Community-based Care HIV/AIDS Waiver in managed care for the reasons stated in comment #12. We also strongly oppose the Governor's Coordinated Care Initiative that requires duals to enroll in managed care for LTSS, regardless of whether they enroll in the demonstration. We urge the state to carve out people living with HIV/AIDS from that requirement, and at a minimum begin a demonstration to discover best practices to incorporate these services and expertise.

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HIV Community	15	17	Starting in June 2013, the State will lead a stakeholder process to develop statewide HCBS Universal Assessment Process. This process shall be implemented no earlier than January 1, 2015.	We appreciate that the state is utilizing a stakeholder process for development of the assessment tool. However, the assessment tool developed for this project must be fully clarified, vetted and articulated prior to the start of the project.
HIV Community	16	25	Notification about Enrollment Process - properly informing beneficiaries about enrollment rights and options will be an essential component of the demonstration, to allow beneficiaries to be educated about plan benefits, rules, and care plan elements with sufficient time to make informed choices.	The movement of SPD into managed care demonstrated that this particular population will need individual assistance in order to ensure a safe transition. This is certainly true of people with HIV/AIDS who we know may not see, understand the relevance of, or be able to act on notifications or phone calls from the state. Ryan White funded benefits counselors and case managers have become trusted sources of information and assistance for people with HIV and must be included in the notification about the enrollment process. Even now, 10 months into the SPD movement, there is serious confusion in the HIV community among patients and providers, and this level of confusion can't be replicated in the transition of dual eligibles. Notification about enrollment process must also include a clear plan for reaching out to providers (including those associated with managed care and those who are not) as well as patients. The SPD movement clearly failed in reaching out to providers outside the managed care system and that included most Ryan White providers.
HIV Community	17	26	Maintain an updated, accurate, and accessible listing of a provider's ability to accept new patients which shall be made available to beneficiaries, at a minimum, by phone, written material, and Internet website, upon request.	The provider's specialty and sub-specialty must also be added to the listing.
HIV Community	18	26	The State will require health plans to follow all continuity of care requirements established in current law	The continuity of care provisions need to be clearly linked not only to providers but to all aspects of medical care including labs and medication.
HIV Community	19	26	The State will require health plans to follow all continuity of care requirements established in current law	Continuity of care provisions need to be significantly strengthened by using a strong stakeholder input process that includes providers and consumer advocates. In addition the provisions need to translated into all Medi-Cal threshold languages and be created in alternative formats. A strong distribution plan that includes plans, providers, and clients must be established in addition to a training and education process. Plans' continuity of care procedures and training plan for implementation must be evaluated and approved by the state. The continuity of care requests must be monitored and results of that monitoring must be made available to the public. If the Governor's plan to have dual eligibles receive their Medi-Cal services only through managed care is approved, a MER system that meet all the requirements of the continuity of care provisions described above must be established. In addition, the MER system must have clear and objective criteria to establish an exemption and rely on the expert opinion of the treating provider for the final determination, as opposed to the current system.
HIV Community	20	27	The State will work with CMS and stakeholders to develop a unified state and federal grievance and appeals process for beneficiaries enrolled in the demonstration.	Appeals and grievances process must be fully articulated and fully vetted through a stakeholder process. There must also be a plan in place for dissemination and explanation of the appeals process to both patients and providers. Timeliness standards. There also has to be monitoring to ensure that the process meets the outline.
HIV Community	21	27	The State will work with CMS and stakeholders to develop a unified state and federal grievance and appeals process for beneficiaries enrolled in the demonstration.	Combining the grievance and appeals process for Medi-Cal and Medicare beneficiaries is complex and must ensure that beneficiaries have the most robust protections they are entitled to under law. It is essential that there is a clear and usable process in place prior to implementation of the coordinated care demonstration. It is also critical that dissemination and education plans for both providers and patients are developed and implemented prior to enrollment in plans.

Organization	Comment #	Page # of Proposal	Relevant Language	Proposal Draft Language & Comment
HIV Community	22	27	The demonstration will include a clear, timely and fair process for complaints, grievances, and disenrollment requests, including procedures for appealing decisions regarding coverage or benefits.	All of these processes must be vetted through a stakeholder process. A dissemination and training plan must be developed and implemented for providers and beneficiaries. All processes must be evaluated and results made available to the public.
Age Tech California	1	15	Use of Technology	**"Use of Technology. Demonstration sites will leverage effective use of technology, although technology will not replace critical in-person care coordination activities. Current health plan efforts and proposals include:**
Age Tech California				
Age Tech California				Greater use of electronic health records throughout the provider network, including web-based sharing of care management plans and updates. These applications allow primary care providers and specialists, including behavioral health specialists, to securely share clinical information, services approved or initiated, and ongoing updates. Electronic consultation between primary care providers and specialists offers improved collaboration, increases efficiency of specialty care visits, and facilitates resolution of members' unmet needs and issues.
Age Tech California				Electronic notices and reminders to primary care providers to help them target certain patients for preventive or follow-up care.
Age Tech California				A provider portal to provide interactive features permitting individualized physician reporting on quality reports.
Age Tech California				Individualized pay-for-performance tools for physicians to report progress in meeting organizational quality goals; these reports serve, in effect, as disease-specific registries for physicians to use in ensuring appropriate diabetes care and other preventative care interventions.
Age Tech California				A new system being developed to integrate data elements from the health plan, and county home-and community-based services and behavioral health agencies to capture a full picture of the medical, social, and behavioral health needs of each beneficiary. "
Age Tech California				**AgeTech CA COMMENT: The Draft CCI Proposal language above is much more narrow and limited to electronic health records (EHRs) and similar HIT functionality vs. the more comprehensive language and questions included in the RFS covering eCare**
Age Tech California				**technology-enabled models.**
Age Tech California				**Please include summary of proposed and recommended use of "eCare" or electronic care technologies in the duals demonstration consistent with the RFS technology questions, and applicant/plan responses.**
Age Tech California				**Recommended revised language for the CCI Proposal:**
Age Tech California				Use of Technology. Demonstration sites will leverage effective use of eCare and health information technologies, although technology will not replace certain in-person care coordination activities. Current health plan efforts and proposals include:
Age Tech California				Greater use of electronic health records throughout the provider network, including web-based sharing of care management plans and updates. These applications allow primary care providers and specialists, including behavioral health specialists, and county home-and community-based services to securely share clinical information, services approved or initiated, and ongoing updates to capture a full picture of the medical, social, and behavioral health needs of each beneficiary.
Age Tech California				Use of remote patient monitoring technologies to enable wellness and continuous care management for high risk members. Such technologies include home telehealth for frequent measurement of vital signs (i.e., blood glucose, blood pressure, heart rate, weight, etc.), medication adherence reminders and dispensing systems, medical alert safety systems, electronic pens for mobile EMR syncing and remote health record access for clinicians.
Age Tech California				Demonstrate meaningful use connectivity through file exchange with disease management and other health information exchanges, eprescribing, real-time health and care status communications to support case management, and reminders to primary care providers to help them target certain patients for preventive or follow-up care."

Organization	Comment #	Page # of Proposal	Relevant Language	Proposal Draft Language & Comment
National Health Law Program	1	10	California proposes to implement the demonstration in the following ten counties: Alameda, Contra Costa, Los Angeles, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Mateo, and Santa Clara Counties. The four counties where the demonstration will be implemented under current state law are: Los Angeles, Orange, San Diego, and San Mateo Counties.	This proposal to implement a demonstration that includes almost three quarters of the dual eligible beneficiaries in CA , in 10 of California's most populated counties, is too large and untested. The initial legislative authority was for only four pilot counties. The state should start with a smaller number, picking only those counties that have demonstrated true readiness, so that the pilot can be adequately tested for its efficacy and effectiveness before expanding it further. Because this is a completely new initiative, it is untested. Including 10 counties is too many. San Mateo and Orange County may both be ready for the demonstration because they have already been responsible for these individuals through the COHS. On the other hand, Los Angeles, which has approximately half of all duals, is too large and it would be too risky and untested to enroll all of these individuals.
National Health Law Program	2	10	The State will use a unified, passive enrollment process through which dual eligible beneficiaries who do not make an affirmative choice to opt out will be automatically enrolled into a demonstration health plan.	NHeLP believes that “voluntary” choice requires an informed and affirmative choice by a beneficiary to participate in a dual eligible integration demonstration (i.e., opt-in). Passive enrollment should not be utilized to enroll these beneficiaries. To the extent that HHS nonetheless permits passive enrollment schemes (i.e., opt-out), NHeLP believes that beneficiaries must be held harmless as to the outcome of the underlying violation of Freedom of Choice. NHeLP recommends that dual integration projects include minimum standards which will guarantee beneficiaries are held harmless, such as advance notice of the right to opt out, enrollment assistance by an independent entity, no lock-ins, and continuity of care with providers. The experience of the SPD mandatory managed care enrollment tells us that there will inevitable be problems with continuity of care and individuals with complex medical conditions losing access to providers. The proposal also includes a proposed "lock-in" of six months, which NHeLP strongly opposes. Hold harmless passive enrollment requires allowing a beneficiary to opt out any time they choose to. Any lock-in period clearly constitutes an infringement on a beneficiary’s freedom of choice and is not permissible. In addition to recommending that the enrollment be opt-in, medical exemptions and continuity of care must also be in place so beneficiaries can maintain fee for service as necessary and appropriate to meet their needs.
National Health Law Program	3	10	Enrollment will be implemented on a phased-in basis throughout 2013	The state cannot adequately and responsibly be ready to implement this demonstration in a responsible manner starting in 2013. There are too many major areas of the plan that have yet to be developed, including notice, appeal and consumer protection processes, LTSS network adequacy standards, care coordination standards. With so much yet to determine, beginning enrollment of beneficiaries during Medicare open enrollment beginning in October will be impossible. In addition, adequate notice and preparation time will require a great deal of lead time to do this correctly. The outline of a proposal, as opposed to the details, is simply not enough. The state should implement this until all of the details are fully developed, including the extensive negotiation with CMS that certainly should occur as well. Enrollment should also be phased in over a longer period than has occurred with the SPD rollout, where there have been many problems and beneficiaries have been harmed.
National Health Law Program	4	10	Stable Enrollment Period: 6-month lock-in.	NHeLP opposes any lock-in period as harmful to beneficiaries. Beneficiaries who are passively enrolled are not electing coverage affirmatively and so locking them in is even more likely to result in a lapse in care or denial of access to necessary services. Even though this proposal states that beneficiaries can continue to see their out-of-network Medicare provider, this is still entirely unrealistic and the SPD experience tells us that continuity of care often is only theoretically available and not actually a reality.
National Health Law Program	5	10	Enrollment Process: Managed care for dual eligible beneficiaries would only be voluntary for Medicare benefits and services, not Medi-Cal.	Medi-Cal portions of the benefit should also be subject to opting out of the demonstration at any time. It makes no sense to have mandatory managed care for Medi-Cal while FFS for Medicare, as the coordination of coverage becomes nearly impossible.
National Health Law Program	6	11	Provider Networks	We support halting new enrollment into a plan if that plan does not have an adequate number of providers. Beneficiaries who were already enrolled in those plans must also be given assistance with, and education on, changing plans should their current plan not meet network adequacy standards. Networks need to not only be adequate geographically and by specialty, but also must account for the needs of language, accessibility and other factors.
National Health Law Program	7	13	Care coordination standards. New standards will be developed in collaboration with public stakeholders.	This is so critical to the implementation of these demonstrations that a proposal cannot be developed without them. Stakeholder involvement is also very important and we support that approach but this is another reason that the demonstration cannot go forward on the current timeline.

Organization	Comment #	Page # of Proposal	Relevant Language	Proposal Draft Language & Comment
National Health Law Program	8	14	Comprehensive health risk assessments and care planning. Health plans are encouraged to provide an active role for members in designing their care plans.	This is a critical area and there is not enough clarity on what the standards and requirements will be. Also, information about the beneficiary must be available in a more timely manner than has been with the SPD transition and plans must be held accountable for addressing urgent needs and honoring ongoing provider relationships for this to be done correctly. Continuity of care must be automatic if requested for any ongoing services. Beneficiaries cannot play an active role in development their care without specific and quantifiable measures of what that means. Plans should be held to a specific standard and monitoring of that standard must be done.
National Health Law Program	9	16	LTSS Care Coordination	The scope of the Duals transition, even in the original four counties specified, is vast enough that incorporating LTSS into a managed care benefit should prevent the state from embarking on adding additional demonstration sites. This is a huge task with which the state is faced, and numerous questions as to incorporating LTSS into managed care remain unanswered or unknown.
National Health Law Program	10	18	Building on lessons from the transition of seniors and persons with disabilities into Medi-Cal managed care, the State will work with plans and providers to ensure necessary processes and procedures are in place to support timely health risk assessments. In addition, California's health plans will use promising practices, such as repeated attempts to gather assessment information, via various modes (phone, mail, interactive voice by phone), web-based care planning tools that allow providers and beneficiaries to view and add to the care plan, etc.	There is extensive evidence that the state has not yet addressed many of the problems or concerns identified with the transition of SPDs. There have been many cases where continuity of care has not occurred, default rates are high, and beneficiaries are switching plans in large numbers, as well as seeking exemptions altogether. This should not be touted as success, despite the survey identifying a small number of individuals who do not voice complaints when contacted. There needs to be better beneficiary outreach and education, more direct and independent consumer assistance, and more monitoring and accountability of plan behaviors. DHCS should not dismiss the number of MER requests as insignificant, since they are the most vulnerable beneficiaries. More time and better information, including health outcomes, is needed before we can say these problems have been addressed.
National Health Law Program	11	22	Design Phase Stakeholder Engagement	Though we appreciate the stakeholder process as it has developed over the past 12 months, we must assert that it has been too large for significant engagement, and only in the past month have the smaller working groups met, which are theoretically responsible for developing actual consumer protections. Considering the state has proposed a January 1, 2013 start date, the preceding stakeholder engagement is not enough and seems to have significantly favored health plans over beneficiaries or consumer advocates.
National Health Law Program	12	24	Ongoing Stakeholder Feedback	The workgroups developed have only met twice in the last two months. This is a good start to the process, but far too abbreviated for a January 2013 start date.
National Health Law Program	13	25	Beneficiary Protections Section	More specific beneficiary protection standards must be developed and be monitored and enforced. In particular, the notice and appeals must follow Medicaid rules, and only more protective Medicare rules should be incorporated in to the Medi-Cal structure.
National Health Law Program	14	25	Notification about enrollment process	Beneficiaries should be given a choice to participate in the demonstration, and this includes an opting in process. Beneficiaries and advocates must be centrally involved in the developing outreach and education materials to beneficiaries and providers and these materials should be literacy tested and compliant with ADA and other laws governing accessibility. HICAPs and Health Consumer Centers should be utilized to do beneficiary education and assistance. The 90 notice must clearly inform beneficiaries of their rights re enrollment, disenrollment and complaint and appeal options, including opting out of the demonstration (if passive enrollment is maintained), for either the Medi-Cal, Medicare or both. These standards must be developed before any proposal is approved.
National Health Law Program	15	26	Network Adequacy and Care Continuity	The demonstration clearly cannot go forward until these standards are developed, communicated to plans and other stakeholder, and operationalized through contracts or other processes. Another reason to delay the implementation as suggested. As described above, this is not currently working in the SPD transition and more specific standards and plans for monitoring and enforcement must be developed before this demonstration goes forward. Simply stating that plans will be required to follow continuity of care requirements is inadequate.

Organization	Comment #	Page # of Proposal	Relevant Language	Proposal Draft Language & Comment
National Health Law Program	16	27	Care continuity: Beneficiaries will have access to out-of-network Medi-Cal providers for up to 12 months (for new members enrolled) who have an ongoing relationship with the provider if the provider accepts the health plan's rate or applicable fee- for-service rate.	As described above, this requirement is not working effectively in the SPD transition as plans are not honoring the requirement or providers and beneficiaries are unclear about the rules. A better and more robust process that is monitored must be developed, including automatic approvals of claims for ongoing care outside the plan with existing providers for the entire 12 months, while care coordination is established in the plan and the plan can demonstrate no lapse in medically necessary care or continuity has occurred.
National Health Law Program	17	27	Appeals and grievances	The existing Medi-Cal appeals and grievance process must continue, as it is adequate and understood by beneficiaries. Only more protective Medicare appeals should be incorporated in to the Medi-Cal structure. Creating a new "hybrid" model will be confusing and mitigate consumer protections and thus should be avoided. A promise that the state will work with CMS to develop a unified process is of concern and no proposal should go forward without this critical part of the proposal being worked out and made clear to everyone. More delay will need to be built in the longer this takes and the more time will be needed to educate consumers advocates and beneficiaries. Additional time for planning this is needed.
National Health Law Program	18	28	State's Ability to Monitor, Collect and Track Data on Quality and Cost	Extensive data on the enrollment process (including exemptions, continuity of care, disenrollment, etc.) plan quality, consumer satisfaction, complaints, grievances and appeals must be available on an ongoing basis and be publicly posted online. Quality benchmarks must be met and data re compliance and plan enrollment suspension should also be available and posted online. The state will need a much more robust infrastructure to do this as they are already struggling to do the minimum monitoring of SPD transition and there are problems not being addressed due to shortage of resources.
National Health Law Program	19	29	Potential Improvement Targets	Although the state will require that demonstration sites be accountable for provider performance within their systems, nothing in the proposal addresses the state's accountability to ensure all of the federal Medicaid and Medicare rules, including access to all medically necessary care with reasonable promptness, due process requirements, etc. are being met. The proposal should address more specifically the state's performance in monitoring outcomes and addressing identified concerns, including specific timelines to respond to problems identified in audits, or though complaints or monitoring.
National Health Law Program	20	31	State Infrastructure/Capacity	As stated above, the capacity of the state to implement this proposal is questionable at best. There are too many very large changes being made to Medi-Cal benefits and the delivery system in CA, not to mention health reform implementation, to take this on and implement it responsibly with existing resources. A state readiness assessment should be required by CMS and conducted by an independent entity.
Southern Caregiver Resource Center				Infornal Caregiver Assessment and Careplanning are omitted from
Southern Caregiver Resource Center				proposal contrary to stakeholder input. Informal caregivers provide
Southern Caregiver Resource Center				$47 billion dollars of unpaid care a year. They are the backbone of
Southern Caregiver Resource Center				our LTc system. To exclude them from any coordinated care model
Southern Caregiver Resource Center				will ipact your ability to achieve outcomes.

Organization	Comment #	Page # of Proposal	Relevant Language	Proposal Draft Language & Comment
Citizens Choice Health Plan	1	11	On page 11 of the proposal (issued April 4th) it states: " Beneficiaries enrolled in Medicare Advantage D-SNPs will be included in the demonstration. The state is developing further details for the D-SNP contracting policy and beneficiary enrollment process under the demonstration." In APL 12-001 (issued April 18th) it says "For a D-SNP to continue operation on January 1, 2013, the D-SNP must either subcontract with a MC Plan that operates in the D-SNP's service area or contract directly with the Department of Health Care Services' (DHCS) Medi-Cal Managed Care Division (MMCD). Before requesting a direct contract with DHCS, D-SNPS must enter into good faith negotiations with all MC Plans operating in their service area." It then goes on to lay out the criteria for a MIPPA compliant contract and the exception policy with respect to direct contracting that the state is willing to allow for the 2013 plan year.	What neither the proposal nor the APL address is the issue of dual eligibles currently enrolled in non-D-SNP Medicare Advantage Plans otherwise called Coordinated Care or CCP plans ("CCP"). There are thousands of dual eligible Californians enrolled in CCP plans rather than D-SNPs. If CCP plans cannot serve as a subcontractor to a participating Medi-Cal plan, there will be enormous disruption in their continuity of care, availability of network providers and, for many, the quality of the care they receive. Therfore our questions are 1) Will CCP plans be allowed to continue serving duals if they obtain a subcontract with a Medi-Cal plan participating in the demonstration? 2) If CCP plans will be allowed to participate via subcontract with a Medi-Cal plan participating in the demonstration and they are currently negotiating that subcontract which is not yet completed, do they need to submit an LOI consistent with the requirements for a D-SNP under APL 12-001? 3) If the state intends to only allow D-SNPs to operate as subcontractors to Medi-Cal plans participating in the duals alignment demonstration program, given that final design of the program (promulgated April 4) was well after the February date that plans would have had to have filed an expansion application with CMS to be a D-SNP in 2013, would the state be willing to allow CCP plans to participate via subcontract with a participating Medi-Cal plan from the go-live of the Duals Demonstration on 1/1/13 until these plans can next become D-SNPs on 1/1/14? And will the state mandate that the Medi-cal Plan allow for CCP's to participate if the CCP passes their due diligence process? 4) If the state is unwilling to provide a bridge for 2013 as described in question 3, would they be willing to seek a special exception from CMS regarding the February expansion application deadline in order to allow CCP plans in this circumstance to file as a D-SNP off cycle?
AIDS Project LA		20	Five Home- and Community-Based Services waiver programs will be included in the demonstration: … [including] HIV/AIDS Waiver Services… Home- and community-based waiver services for adults with developmental disabilities will be carved-out of the demonstration. ... Further, under the Governor's Coordinated Care Initiative, these waiver programs would become managed care benefits available only through enrollment in Medi-Cal managed care health plans, in counties where the demonstration is implemented.	Similar to the waiver for adults with developmental disabilities, the 1915c Home- and Community-based care AIDS Waiver should be carved out of the demonstration. The services provided under this waiver have been developed over the past two decades, resulting in an invaluable infrastructure for a small and very vulnerable patient population. These unique and specialized services have never been part of a managed care system. At most, the State could begin to explore the intersection of AIDS Waiver services and managed care, but only after an active enrollment process for people with HIV/AIDS as well as the tested integration of these services into a managed care system on a case-by-case basis, as opposed to the wholesale subsumption of these services into managed care plans. Further, although the plans might provide additional benefits such as vision, dental, non-medical transportation, housing assistance and home delivered meals, etc., they are not required to do so. At the same time, people with HIV/AIDS risk losing access to their specialized Ryan White services due to lack of clarity and specificity of what the plans will offer and Ryan White payer of last resort rules. These wrap-around and specialized services are a critical component to patients remaining in care and living with this chronic condition. Finally, plans should be made responsible for incorporating the full AIDS Drug Assistance Program (ADAP) formulary, including dosing schedules and utilization management requirements.
AIDS Project LA		20	The State is considering options for how new enrollment in these waiver would be treated under the demonstration, anad welcomes stakeholder feedback on this issue.	For the reasons stated above, the State's AIDS Waiver should be at least initially carved out of the demonstration.

Organization	Comment #	Page # of Proposal	Relevant Language	Proposal Draft Language & Comment
AIDS Project LA	3	21-22	The State proposes that integration of these waiver programs with demonstration health plans will include the following activities: (1) development and implementation of comprehensive, non-duplicative, personalized care plans and a care coordination process that includes the waivered services and other medical and LTSS services needed by these individuals; (2) transfer of care management functions to demonstration health plans; and (3) integration of waivered services as part of supplemental service offering of the demonstration plans. Upon completion of these activities, the State is considering whether waiver programs would cease to take on new beneficiaries and all waivered services and care coordination would be undertaken by the demonstration plans. In Demonstration counties, the waiver programs would continue to operate until the end of the waiver periods for existing waiver recipients.	In addition to the duals beneficiaries who would be impacted by the proposed demonstration, many other patients access services through the AIDS Waiver. Therefore, it is imprudent and premature for the State to suggest the cessation of the AIDS Waiver based on its intent to subsume a subset of the AIDS Waiver population into an as-yet unimplemented, unproven demonstration. The needs of this relatively small patient population are specialized and the services provided under the AIDS Waiver require an expertise and skillset that has taken years to develop and cannot easily be duplicated or replaced. For these reasons, the AIDS Waiver should be at least initially carved out of the demonstration, and the State could explore the intersection of AIDS Waiver services and managed care on a case-by-case basis.
Alzheimers Association of California	1	2	Accessible to enrollees	In order to ensure that a person with cognitive impairment receifes the appropriate information, the information needs to be delivered to caregivers also.
Alzheimers Association of California	2	9	Person-Centered coordination	In order to ensure that a person with cognitive impairment do not fall through the cracks, cognitive impairment must be part of the health risk assessment.
Alzheimers Association of California	3	10	Enrollment process	passive enrollment has the potential to cause disruption in care for persons with cognitive impairment - espcially those that live alone. Accomodations must be made to ensure continuity of care.
Alzheimers Association of California	4	11	Beneficiaries will be informed	same as comment #1

Organization	Comment #	Page # of Proposal	Relevant Language	Proposal Draft Language & Comment
Alzheimers Association of California	5	11	Provider networks	In order to ensure that Alzheimer's patients and persons with dementia are served appropriately. The network must include neurologists, geriatricians with dementia expertise and geriatric psychiatrists.
Alzheimers Association of California	6	12	Supplemental Benefits	Training in dementia care must be mandatory for the providers
Alzheimers Association of California	7	12 & 13	Merge Medical and Social Srvs	The Alzheimer's Association should be added to the list of organizations
Alzheimers Association of California	8	14	Person centered	same as comment #5
Alzheimers Association of California	9	15	Case Managers	same as comment #6
Alzheimers Association of California	10	15	Use of Technology	Less than 20% of persons with Alzheimer's disease have it documented in their medical record. Providers must be required to not only conduct the assessment but document it into the chart.
Alzheimers Association of California	11	15	Behavioral health care	We are encourged to see cognitive limitations, Alzheimer's Disease and related dementias mentioned.
Alzheimers Association of California	12	18	Evidence- based	The California Guidelines for Alzheimer's disease management must be included.
Alzheimers Association of California	13	21	MSPP and CBAS	Both programs need to ensure that dementia training - certification - is mandatory
Alzheimers Association of California	14	24	Ongoing Stakeholder	In order to ensure a true collaboration where each and every stakeholder is heard, a process must be developed to respond to stakeholder comments and suggestions.
Alzheimers Association of California	15	25	self direction of care	A process must be put into place to ensure that a caregiver has decision making authority in this process.

Organization	Comment #	Page # of Proposal	Relevant Language	Proposal Draft Language & Comment
Alzheimers Association of California	16	25	Notification	This section will need to be watched closely to ensure that persons with cognitive impairment and/or their caregivers understand their enrollment rights.
Alzheimers Association of California	17	26	Health Risk Assessment	Add - Assesses each new enrollee's risk leve and needs - "along with their cognitive status and ability to make informed decisions."
Alzheimers Association of California	18	28	Performance based	In order to ensure that the patient is managed correclty a higher rate of reimbursment must be added for providers whom are caring for persons with Alzheimer's disease/dementia
Alzheimer's and Related Disorders Advisory Committee	1	2	This information will be delivered in a format and languale accessible to enrollees	How will the state assure that cognitively impaired people get this information as described?. An estimated 20% live alone.
Alzheimer's and Related Disorders Advisory Committee	2	3	Evaluation of quality and satisfaction	If the intent is to have some kind of consumer questionnaire, there must be allowances made for the caregiver to contribute responses in the event the person with dementia cannot.
Alzheimer's and Related Disorders Advisory Committee	3	9	Person-Centered Care Coordination	Health risk assessments must include consistent language for assessing cognitive impairment. Included must also be assessment as to what caregiving assistance is available for a person with cognitive impairment or a more advanced form of dementia.
Alzheimer's and Related Disorders Advisory Committee	4	10	Passive enrollment process	If a person with dementia lives alone with no close-by caregiver support, they could easily fall through the cracks. What systems will be in place to ensure this does not happen? Assignment of a new PCP, if that occurs, must take into account the need for dementia competency.
Alzheimer's and Related Disorders Advisory Committee	5	11	Provider Networks	People with Alzheimer's may need specialty care from Geriatric Psychiatrists but a couple of problems exist. One, there is a mental health carve out, so even if Counties provide behavioral health care, they exclude people with Alzheimer's even when mental health issues are present. Two, if managed care incorporates mental health at some stage, the unique needs of people with dementia must be explored. Behavioral issues must be reviewed in light of treatments other than medication which can be disastrous for someone with dementia.
Alzheimer's and Related Disorders Advisory Committee	6	11 &26	Provider Networks	We need to assure that the network includes neurologists or geriatricians with dementia expertise. Specifically, we need to ensure that PCPs don't "dismiss" (as they often do) memory or cognitive problems by referring tp those problems as a "natural aging" process.

Organization	Comment #	Page # of Proposal	Relevant Language	Proposal Draft Language & Comment
Alzheimer's and Related Disorders Advisory Committee	7	11	Non-emergency help lines staffed 24/7	Consider the need to have community referrals such as the Alzheimer's Association hot line number as these can be a tremendous help for someone in crisis in the middle of the night when it's not a medical emergency.
Alzheimer's and Related Disorders Advisory Committee	8	12	Supplemental Benefits	Community based services (e.g. IHHS, CBAS and MSSP) can help keep people out of the hospital and in their communities only if they are well trained in dementia care. The person with dementia must be assessed along with an evaluation as to what care is available at home. If the person lives alone, safety issues are a concern.
Alzheimer's and Related Disorders Advisory Committee	9	12	Care Management	Alzheimer's/dementia must be considered as one of the "diseases" to be "managed". Along with this, access to quality diagnostic centers is essential. Ways to partner with organizations such as the Alzheimer's Disease Centers should be explored
Alzheimer's and Related Disorders Advisory Committee	10	15	Upon receipt of the referral, care managers conduct a comprehensive assessment,	Care managers must have core competencies which include training in dementia care management. By understanding the disease and having the requisite skills, care can be not only higher quality but more cost effecitve.
Alzheimer's and Related Disorders Advisory Committee	11	16	Use of technology	Fewer than 20% of people with Alzheimer's disease have it coded in their medical records. For technolgy to be effective, assessments and diagnostic work-ups will need to be completed.
Alzheimer's and Related Disorders Advisory Committee	12	17	New Universal Assessment Tool	How can we assure this tool takes into account the cognitively impaired person's functiional capacity including the need for prompting? Currently, some LTSS providers cannot assess the needs of this population. There is a need for training.
Alzheimer's and Related Disorders Advisory Committee	13	18	Evidence-based Practices	We need to assure that the "California Guidelines for Alzheimer's Disease Management" are used by all providers to develop systems of care for people with dementia.
Alzheimer's and Related Disorders Advisory Committee	14	21	MSSP, CBAS and waiver programs	The State needs to assure that these service providers are competent to serve vulnerable people with dementia. A certification program with appropriate training might be beneficial. Otherwise, dementia patients will continue to cost the state more through Medicaid than other benficiaries and cost Medicare 3 X more than other beneficiaries because they will not be receiving appropriate care. Being in a supportive environment is often helpful for someone with dementia, and is essential if they live alone with no other stimulation. Often a board and care or assisted living facility is required rather than having the person with dementia live at home, but the cost factors make it impossible for someone with little or no money. Need to ensure the waiver programs cover this population.
Alzheimer's and Related Disorders Advisory Committee	15	24	Stakeholder feedback	Advocacy groups may be asked to serve on advisory committees but there needs to be a commitment on the part of the managed care plans that there will be a true partnership. What is being done to ensure that?

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Alzheimer's and Related Disorders Advisory Committee	16	25	Self-direction of care	Accommodations must be put in place to assure that surrogate decision makers are vetted AND that they can give input on a patient's care. Attention should be given to helpful forms that need to be completed before someone becomes cognitively impaired (e.g. health directives).
Alzheimer's and Related Disorders Advisory Committee	17	25	Notificatin about Enrollment Process	"Properly informing beneficiaries (or, as appropriate, their surrogate decision-makers) about enrollment rights…" There is still going to be a problem determining which beneficiaries have cognitive impairment and need a surrogate.
Alzheimer's and Related Disorders Advisory Committee	18	26	Health Risk Assessment	Please add: "Assesses the new enrollee's cognitive status and capacity to make informed decisions."
Alzheimer's and Related Disorders Advisory Committee	19	26	Network Adequacy	As stated previously, need to go beyond the "traditional" measures of network adequacy and drill down to specific competencies for dementia and how to measure that.
Alzheimer's and Related Disorders Advisory Committee	20	28	Performance-based reimbursement	People with dementia often need more quality time with a health care practitioner. Provider reimbursement needs to account for such patients; they may not fit the traditional definition of "medically complex", but there are mutliple other issues to deal with if the person is to be kept healthy (and therefore save the health system money in the long run)..
Alzheimer's and Related Disorders Advisory Committee	21	28	Outcomes	People with dementia/Alzheimer's must be identified and tracked.
Shield Health Care	3	11	*Provider Networks*	The proposal talks about provider networks and the State making sure that health plan provider panels are adequate to meet the needs of dual eligible members. For this demonstration the term provider must be broadened to include more than just primary & specialty care doctors and long-term services and supports. One important lesson learned from the SPD transition was that there were limited efforts by the State and the health plans to engage fee-for-service providers of ancillary services (like DME suppliers and pharmacies). These non-medical providers play an important role in caring for dual eligible beneficiaries and keeping them at home away from more costly places of care. Ancillary providers need to be included in the monitoring and discussions about network adequacy.
Shield Health Care	4	13	*Benefit Design and Supplemental Benefits*	The last part of the section notes that MCL and MCR medical necessity standards will not be restricted by health plans, ensuring that individuals have access to any benefits they would have had absent the demonstration. What has not been made clear by the proposal is how differences in coverage policies, quantities and documentation requirements will be sorted out between payors. What are beneficiaries and providers supposed to do when rules, policies or standards are misaligned? Will MCR trump MCL (or vice versa) or will the health plans decide for themselves which to follow? Dual eligible beneficiaries must be able to maintain their access to the same benefit levels they have today.
Shield Health Care	5	24	*Ongoing Stakeholder Feedback*	Shield welcomes the opportunity to participate in meaningful stakeholder input. We hope that the State will engage providers through more than phone calls or town hall meetings. Stakeholders want to know that their comments and feedback are taken seriously ant that DHCS gives thoughtful consideration before taking action.

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Shield Health Care	6	26,27	*Network Adequacy and Care Continuity*	The proposal is clear that beneficiaries will have a choice of providers from a broad network of providers including primary care, behavioral health, specialists, ancillary, hospitals, pharmacists and LTSS providers. The State further requires health plans to follow all continuity of care requirements under current law. This is important because with the SPD transition the concept of care continuity changed more than once. The final MMCD All Plan Letter (11-019) came out two and a half months after the transition began and specifically excluded ancillary providers like DMEs and medical product suppliers. Dual eligible beneficiaries have a right to maintain relationships with their long-standing care providers and the out-of-network provision should apply to all provider types referenced in this section.
Shield Health Care	7	35	*Feasibility and Sustainability* - Ambitious Timelines	This compressed timeline is somewhat aggressive given the large number of beneficiaries impacted and the inherent complexities associated with implementing new demonstration projects. The proposed timeline negates the State's opportunity to take advantage of any lessons learned (both bad & good) from the SPD transition.
Community Clinics of LA Association	1	10	"…once enrolled in a demonstration site, beneficiaries will have another opportunity to opt-out after a six-month stable enrollment period…the State will identify any beneficiary categories that may opt out during the six-month stable enrollment period."	While patients are able to see an out of network provider for a limited period of time during the transition, this is only if that provider agrees to certain conditions. If a patient is required to change providers, what is the protocol for the transition? DHCS must ensure that patients can be transferred without a disruption to their care. This challenge also makes clear notification necessary well in advance. Patients must receive notice beyond one phone call or mailing that explain the changes they will experience. CCALAC highly recommends working with patients' current providers well in advance of the transition as patients often respond better when communicating with providers with whom they are already familiar.
Community Clinics of LA Association	2	11	"Beneficiaries will be informed of their enrollment rights and options, plan benefits and rules, and the care planning process in an accessible format and with sufficient time to make informed choices."	The DHCS plan identifies various formats for communication (e.g. sign language, captioning, translation, etc.) and also recommends written notification at no more than a sixth grade reading level. Clear and adequate communication did not occur during the transition of Seniors and Persons with Disabilities (SPD) into managed care. SPD patients at several CCALAC member clinics were assigned to other primary care providers without their knowledge. Literature provided to patients was challenging to understand. CCALAC looks forward to a better understanding of how this communication will be improved.
Community Clinics of LA Association	3	11	"Health plans have suggested a partnership/contracting relationship local advocacy organizations to assist with outreach, to help potential enrollees understand the importance of active engagement early in the enrollment process. In addition, health plans may also partner with current providers and case managers to explain the benefits of participating in the demonstration."	The notification process must begin for beneficiaries before the 90-day period suggested by DHCS. As mentioned above (Comment #1), CCALAC recommends working through patient's existing providers as much as possible to assist in educating their patients on the changes they will experience during the transition.
Community Clinics of LA Association	4	11	"Each health plan will be subject to a joint state-federal readiness review before any beneficiaries are enrolled...If the state determines that a health plan does not have sufficient primary or specialty care providers and long-term services and supports to meet the needs of its members, the State will suspend new enrollment of dual eligible beneficiaries into that health plan."	It is unclear how health plan readiness will be addressed. During the SPD transition, several clinics were forced to close to all Medi-Cal assignments on a temporary basis due to reaching their capacity on the number of SPD assignments. A significant contributing factor to this was a high percentage of default assignments (nearly 70 percent) that were going to safety net providers. This results in a "cascade" effect that places additional burden on other providers within the system. Health plans must include providers in discussions on communicating with providers on their capacity and how patients will be defaulted to providers.

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Community Clinics of LA Association	5	13	"Care Coordination Standards. New standards will be developed in collaboration with public stakeholders. Standards will enable improved monitoring and follow-up to determine whether the services were received, effective, still needed and whether additional intervention is necessary."	Stakeholder involvement in care coordination was poor during the SPD transition. Already busy clinics were crowded with even more anxious, sick and many times mentally ill patients, in crisis needing urgent refills, durable medical equipment or surgical procedures. Clinic staff were left to sort out the complex maze of their previous care and doctors had to assess medical status without any prior records. This required significant additional staff resources that clinics were never compensated for. CCALAC looks forward to future discussion with DHCS and health plans on how the care coordination process will be improved.
Community Clinics of LA Association	6	14	"…the State will work with plans and providers to ensure necessary processes and procedures are in place to support timely health risk assessments."	Many SPD patients had their providers abruptly changed leading to many instances of patients with urgent needs demanding immediate assistance from clinics staff who then often worked for hours attempting to coordinate care for such individuals. In an assessment by one clinic during the SPD transition, they found that only 11% had their Health Risk Assessment completed and when it could be found, it was woefully inadequate. At times the assessment merely said "PCP and Case Manager to coordinate ongoing PCP visits" and the "member will schedule, complete and maintain regularly schedule PCP visits." These assessments were done for incredibly complex patients. The assessments were also done by phone without personal contact and no contact was made with the physician. This not only impacted the patients but also already stressed clinic staff struggling to manage multiple forms and process changes for other programs (e.g. Healthy Way LA, LA County's Low Income Health Program). CCALAC is hopeful that the assessment process and protocols will be improved for the implementation of the Duals transition in 2013.
Community Clinics of LA Association	7	14	"Demonstration plans will offer person-centered medical homes with multidisciplinary care teams…The care teams…will ensure decisions are made collaboratively…"	CCALAC member clinics are on the front lines of developing patient centered medical homes. It appears in the DHCS plan that often members of a particular "care team" will not be located at the same site. How will these "team" members collaborate? Considerable thought must be given to how team members communicate with each other. There will need to be adequate training on these methods for providers as well. CCALAC looks forward to learning more about how these care teams with members from across the system will communicate.
Community Clinics of LA Association	8	14	"Care Transitions….Health plans have implemented evidence-based interventions to ensure safe, coordinated care so that beneficiaries remain in the least restrictive setting that meets their health care needs and preferences."	CCALAC looks forward to learning how care transitions will be better facilitated than they were during the SPD transition. As stated above (Comment #6), many patients were not educated well enough in the transition, leading to many patients assigned to clinics who clearly could not be treated there. Clinics were often receiving patients who clearly needed specialty care and other services that CCALAC member clinics could not provide.
Community Clinics of LA Association	9	15	"Health plans will ensure warm hand-offs and follow-up care for coordinating needed behavioral health services…Several are supporting efforts to co-locate behavioral health and primary care services."	The L.A. Care RFS Response states, "we do not currently have warm hand off protocols but will develop and implement such processes with CompCare in the Dual Eligible Demonstration." Many of CCALAC's member clinics already integrate behavioral health and primary care services. Currently, CCALAC member clinics are already working with LA County's Department of Mental Health to integrate mental health services through LA County's LIHP program, Healthy Way LA. CCALAC hopes that clinic experience with integrated behavioral health is taken into account as these protocols are developed.
Community Clinics of LA Association	10	18	[Context: SPD Transition] "A telephone survey of 463 newly transitioned beneficiaries (out of 5,000 called) in February 2012 yielded positive results…Four percent of the beneficiaries who were scheduled to transition to Medi-Cal managed care made a Medical Exemption Request to remain in fee-for-service Medi-Cal."	It is unclear whether the DHCS survey on transition satisfaction is representative of the broader beneficiary experience as 463 beneficiaries appears to be quite a small sample. LA County experienced a significantly high number of default provider assignments and this has largely been attributed to poor communication to beneficiaries, not the willingness of beneficiaries to be auto-enrolled in managed care. In one clinic's assessment, they counted receipt of over 1,000 SPD patients and well over half were new patients to the clinic. Only 24 percent of those patients had chosen the clinic.

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Community Clinics of LA Association	11	19	"The SPD transition reinforced that phone calls to beneficiaries, without additional outreach, are not adequate to ensure they understand changes in the enrollment process and their rights."	This is absolutely true. CCALAC recommends the use of multiple avenues to communicate changes to beneficiaries including written communication, phone communication and communication from current providers in order to provide the smoothest possible transition for patients. These communications must be made well in advance of January 2013 to allow for patients and providers to be fully prepared.
Community Clinics of LA Association	12	19	"Medi-Cal managed care health plans will have had many months to adapt to the to the unique needs of the SPD population and to adjust their networks accordingly."	While it appears that plans will have had much time to address the challenges evident in the SPD transition, much work remains to be done with the health plans to ensure that these issues are resolved. While DHCS states that a state-federal readiness review process will take place, it is unclear how adjustments to challenges specific to the SPD transition will be evaluated.
Community Clinics of LA Association	13	25	"The state will…at least 90 days prior to enrollment, inform dual eligible beneficiaries through a notice written at no more than a sixth grade reading level that includes, at a minimum: how their Medi-Cal system of care will change, when the changes will occur, and who they can contact for assistance..."	CCALAC recommends that DHCS consider written communication with beneficiaries earlier than the 90 days suggested in their plan. Many times patients need significant additional follow up to ensure adequate education and affirmative selection. In the case of assistance contact, CCALAC member clinics also experienced challenges during the SPD transition. Members reported receiving recorded messages when calling the State Ombudsman and were told to leave messages, which were not returned. This was very inadequate given the urgent situations many clinics were faced with. CCALAC recommends an improved ombudsmen line services so that the needs of patients and providers are met.
Community Clinics of LA Association	14	26	"The State will require that health plans…Maintain an updated, accurate, and accessible listing of a provider's ability to accept new patients which shall be made available to beneficiaries, at a minimum, by phone, written material, and Internet website, upon request."	As stated above (Comment #4), CCALAC member clinics experienced capacity challenges during the SPD transition that led to a "cascade" effect across the system. While publishing the ability of providers to accept new patient will be helpful to those patients actively engaged in the transition process, a clear communication process between health plans and providers must be established to ensure proper default assignment of patients. Clinics must have ongoing communications with plans, particularly in the early phase of the transition, for adequate monitoring of clinic capacity.
Community Clinics of LA Association	15	27	"Beneficiaries will have access to out-of-network Medi-Cal providers, for up to 12 months, for new members enrolled under the demonstration who have an ongoing relationship with a provider if the provider will accept the health plan's rate for the services offered, or applicable Medi-Cal fee-for-service rate, whichever is higher..."	Many of CCALAC member clinics reported a poor link between them and the patient's former provider which led to difficulties in care coordination and the basic provision of care for patients with very complex health needs. CCALAC recommends that a link be established between the old and new providers to facilitate adequate communication as the new provider gets to know the patient. This link must be established and housed at the health plans and IPAs before the transition so that they can facilitate this communication when necessary.
Community Clinics of LA Association	16	34	"Health plans will also need to strengthen their engagement and collaboration with providers, as part of the care coordination efforts."	Clear communication is needed for clinics to understand where the main responsibility for care coordination lies. LA Care's RFS Response states that the responsibility will depend on the sophistication of independent physician associations. This delineation must be clearly communicated to providers. During the SPD transition, CCALAC member clinics experienced confusion around which entity was responsible for various functions. In one case, a blind patient with diabetes was new to a clinic and needed a talking glucometer. It was not clear whether the HMO or the IPA was responsible for this piece of equipment. The request bounced back and forth until finally the clinic utilized a personal relationship within the health plan to get the equipment. Responsibilities must be clearly and effectively communicated to providers to facilitate timely and appropriate care for patients.

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Community Clinics of LA Association	17	35	"Tight CMS timelines will require an ambitious approach to implementation."	Tight timelines have lead to very damaging consequences in past efforts including in implementation of LA County's Low Income Health Program (LIHP), Healthy Way LA (HWLA). In hindsight, LA County enrollment and claiming systems were not adequately prepared for implementation of the new program and resulted in enrollment inefficiencies, backlogs and the significant delay of payment to CCALAC member clinics. This resulted in dangerous cash-flow challenges. Such tight timeframes require an even more vigilant approach when evaluating health plans, providers and IPAs for readiness. CCALAC strongly suggests that DHCS engage in a robust evaluation of readiness before implementation of the transition in 2013.
Prime Care Medical Networks	1	10	Stable Enrollment Period. Further, under the proposed Initiative, once enrolled in a demonstration site, beneficiaries will have another opportunity to opt-out after a six-month stable enrollment period during which health plans must ensure continuity of care.	Stable Enrollment Period. Further, under the proposed Initiative, once enrolled in a demonstration site, beneficiaries will have another opportunity to opt-out after a 12-month stable enrollment period during which health plans must ensure continuity of care. *Comment: A period of at least 12 months is necessary to allow time for providers to assess the health care needs of the beneficiary, develop and implement a care plan and monitor the impact. Allowing the beneficiary to opt-out after six months, will not be clinically beneficial to the patient and opting out may delay care.*
Prime Care Medical Networks	2	25	Self-direction of care: Select their health providers in the managed care plan network and control care planning and coordination with their health care providers;	Self-direction of care: Select their health providers from a managed care plan network of providers and control care planning and coordination with their health care providers; *Comment: Added language that requires selection of a primary care provider and a defined managed care network as the designated network of specialists contracted with the PCP's provider organization, as this will contribute to better care coordination*
Prime Care Medical Networks	3	26	Ensure that each health plan has non-emergency medical transportaion available in sufficient supply and accessibility so that individuals have timely access for scheduled and unscheduled medical care appointments	State and health plans will mutually develop and agree upon financially reasonable and sustainable transportation options to ensure that each health plan has non-emergency medical transportaion available in sufficient supply and accessibility so that individuals have timely access for scheduled and unscheduled medical care appointments. *Comments: Given the potential cost of providing this unlimited benefit, the parties need to collaborate to assess how this benefit can be sustained in the long term without compromising resources dedicated to any other health plan quality programs.*
Prime Care Medical Networks	4	27	Beneficiaries will have access to out-of-network Medi-Cal provider, for up to 12 months…	Beneficiaries will have access to out-of-network Medi-Cal provider, for up to six months… *Comment: Six months is adequate time to transition a beneficiary into a coordinated care network, and will be better aligned with the State objective to "Coordinate state and federal benefits and access to care across care setting, improve continuity of care and use a person-centered approach"*
Prime Care Medical Networks	5	27-28	Rates for participating health plans will be developed by the State in partnership with CMS based on baseline spending in both progams and anticipate savings that will result from integration and improved managed care.	Rates for participating plans will be developed by the State in partnership with CMS based on a risk adjusted methdology and adjusted for any new services required by CMS or the State not currently provided under either the State or CMS or any supplemental benefits. *Comments: Risk adjustment will account for any adverse selection amongst provider networks, as a contracted provider organization may be located in part of a county with a higher number of high risk beneficiaries, due to geography, proximity to tertiary care hospitals, specialty network, etc.*
Prime Care Medical Networks	6	28	The State is also considering quality incentives, in addition to the CMS required withholds.	The State is also considering quality incentives, in addition to the CMS required withholds, in which measures consistent with the CMS 5-Star and State managed care Medicaid programs shall be used. *Comments: Providers are highly concerned with the number of different quality incentive programs with varying or overlapping metrics that require significant physician and staff time, and often sophisticated systems, to track. Consistency amongst the quality metrics will be more efficient and enable physicians to have more time for direct patient care.*
Prime Care Medical Networks	7	34	In addition, the State assumes that it will receive 50 percent of the combined Medicare and Medi-Cal federal and state savings from this demonstration	Recommend that current language be deleted in its entirety. *Comment: Per the proposal, State will be adjusting the base rate for any anticipated savings; therefore sharing in any additional savings, if that was the intent of the original language, would not be reasonable given that the plans and any delegated provider organizations are assuming the financial and clinical risk to generate added savings.*

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Prime Care Medical Networks	8	43	October 2012 to December 2012: Medicare Open Enrollment	October 15 to December 7 2012: Medicare Open Enrollment *Comment: It will be more efficient afor those dual eligibles aged 65 or greater, plans and provider organizations to have an enrollment period consistent with Medicare Advantage*
Inglewood Imaging Center	1	1	capitated payment model	This is very troubling for LA County providers. We have had a terrible time working with the managed care organizations in the past. They don't pay. Pay slow. Provide outdated treatment options to patients, eliminate competition by "captitate" network, redirect referrals, have gone bankrupt, and pay often wrong amount. Independent MD's and providers in this model will be potentially bankrupt & the patients will lose their long terms care providers.
Inglewood Imaging Center	2	2	In 2013, California intends to implement the demonstration in ten counties.	This is troubling timeline. Most MD's in LA County who are independent are unaware of this legislation. Also, the patients will suffer tremendously by losing their Medicare benefits. If this is going to be enacted, sufficient notice needs to be made to the AMA, AARP, Medical Boards and community programs so both the patients and market can prepare for such legislation.
Inglewood Imaging Center	3	2	selection process to identify health plans with the requisite qualifications and resources best suited to participate as demonstration	This is a bogus line. The State providers have horrible reputations of not paying and eliminating patient care. See example of this, http://www.californiahealthline.org/articles/2011/7/7/state-levies-fine-against-la-care-health-plan-for-claims-mismanagement.aspx
Inglewood Imaging Center	4	2	lessons learned during the 1115 waiver	The Waiver transition was a disaster. Cancer patients I know had treatment delayed/postponed mid-cancer treatment. The patients will suffer tremendously.
Inglewood Imaging Center	5	3	providing seamless access to robust networks of providers	This is not correct. The IPA frequently capture the payment on the patient then own the ancillary services in violation of the Federal Anti-kick Back statute. Additionally, specialist will all suffer as it is very common for their network to be "full". Additionally, many specialists get paid too little to cover expenses (oncology for instance) resulting in defections from MD's out of the area.
Inglewood Imaging Center	6	3	Transparency and meaningful involvement of external stakeholders	Interesting wording. None of the LA County 375,000 patients are familiar with the plan. Also, almost all MD's are not aware of the plan. I reviewed the attendees list and I didn't see any MD's or patient advocacy groups in attendance.
Inglewood Imaging Center	7	4	but too often they receive services that are "fragmented, incomplete, inefficient, and ineffective"	How will replacing their providing MD's help the patient. The MD has a life long relationship with the patient and is trained to treat them. The Medi-Cal change last year has resulted in lost patients not vice versa.
Inglewood Imaging Center	8	5	costs.3 Medi-Cal spending on dual eligible beneficiaries in 2007 was about $7.6 billion, or about 23% of total Medi-Cal spending, although dual eligible beneficiaries comprised just 14 percent of the total Medi-Cal population	This statistic is misleading. Medi-Cal patient alone are younger generally. The Medi/Medi patients represent an older patient population that requires more care.
Inglewood Imaging Center	9	6	new system must be built on a foundation of strong beneficiary protections and ongoing stakeholder engagement.	The stakeholder in this program who benefit are insurance carriers not the MD nor patient.
Inglewood Imaging Center	10	6	Person-centered care planning.	Their current treating MD is the best person for this.
Inglewood Imaging Center	11	6	HCBS is reduced hospitalization, particularly since hospitalization is often a precursor to a nursing facility placement.	The State should consider revising the EMTALA law.
Inglewood Imaging Center	12	7	Emphasis on Prevention.	Should the State invest in healthy living at the elementary education level.

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Inglewood Imaging Center	13	7	Streamlined and simplified service delivery	Instead of this program, the State should invest in a common EMR to manage the patients care.
Inglewood Imaging Center	14	7	Enhanced quality monitoring and	How will this be defined? Currently most IPA's redirect all referrals to the cheapest/worst provider or eliminate care.
Inglewood Imaging Center	15	9	Managed care done well leads to high quality care.	What defines "done well"? The patients suffer by not receiving care. The MD suffers by not being allowed to participate in the managed care network. Providers suffer by not being allowed to contract with the managed care organization's "full network".
Inglewood Imaging Center	16	10	Proposed Delivery System: Coordinated Care Delivery through Managed Care Organizations	Pretty scary prospect. Approximately 1/3 of the Medical Groups go bankrupt.
Inglewood Imaging Center	17	9	the State held a rigorous selection process through which 13 health plans submitted 22 applications and participated in in-person interviews with State officials	According to the California Healthcare Foundation, 13% of Medical Groups go bankrupt. La Vida, an LA County IPA for instance, went bankrupt in 2010. Patients lost medial records. Providers lost revenue.
Inglewood Imaging Center	18	18	Managed Fee-for-Service Model	Wouldn't it be better to integrate a 3rd party authorization group (i.e. Magellan) to complete this for CMS Medi/Medi? Much more efficient and would weed out inappropriateness.
Inglewood Imaging Center	19	18	Evidence-based Practices	I am in agreement. L:ooks to national guidelines (i.e. NCCN) and coordinate care based on what works.
Inglewood Imaging Center	20	25	Notification about Enrollment Process.	The date of demonstration needs to be pushed back. The program is still being developed and the public needs to prepare for this. The Demonstration was not known by the end patient nor MD, so you need to protect both of them.
Inglewood Imaging Center	21	35	Ambitious Timelines:	Please, please, please push the start date back, Honestly this project will bankrupt a large % of Demonstration county MD's and providers. Independent MD's have no clue about this program and sufficient time must awarded.
SEIU	1	9	Care Model Overview	At least sixty days prior to entering into any contract with a managed health care plan, the State should make available for comment and review by stakeholders and the Legislature the language of the proposed contract.
SEIU	2	10	C. Care Model Overview: Enrollment Process	While beneficiaries who opt-out of the demonstration on the Medicare side would still be enrolled in managed care for the delivery of their Medi-Cal-only benefits and services, beneficiaries should have the option to decline having their IHSS services coordinated by the managed care plan. Financial integration into Medi-Cal managed care should in no way require the beneficiary to have their IHSS services managed or coordinated by the Medi-Cal plan.
SEIU	3	10	Enrollment Process: Stable Enrollment Period	With careful attention to continuity of care issues, passive enrollment with the option to opt-out of receiving Medicare benefits and services under managed care will ensure a reasonable balance between the needs of the plan and the success of the Demonstration with consumer choice and protection. However, the six-month stable enrollment period unnecessarily curtails consumer choice and infringes on the protection opting-out gives beneficiaries in deciding where and how they receive their care, and it should be eliminated from the demonstration proposal.
SEIU	4	10	Enrollment Process	In a passive enrollment process where beneficiaries who do not make an affirmative choice to opt out, the state should establish a formula for automatic enrollment that favors enrollment into a public MC plan.
SEIU	5	14	Person-Centered Care Coordination: Person-Centered medical homes and interdisciplinary care teams (ICT)	Health plans must preserve the beneficiary's choice to have their IHSS services coordinated through their managed care plan as well as to integrate their IHSS provider onto their ICT. No matter what beneficiaries choose, they must maintain their right to direct their own care and hire, fire and supervise the IHSS provider of their choosing.
SEIU	6	14	Person-Centered medical homes and interdisciplinary care teams (ICT)	If a consumer opts to have their IHSS coordinated throught their managed care plan, they must have the choice to have their IHSS provider participate as part of their ICT. In these cases, the consumer should play an active role - with their IHSS provider - in designing and implementing their care plan.
SEIU	7	14	Person-Centered medical homes and interdisciplinary care teams (ICT)	IHSS providers, particularly those who participate on the ICT, should have access to training to help them provide better, more individualized, care for their consumers. All trainings should be developed with consumer input.

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SEIU	8	14	Care Transitions	Health plan care transition interventions must always prioritize the beneficiary's choice of setting regarding where they receive care and must include every possible benefit to ensure the beneficiary's social and medical needs are met in that care setting. Beneficiaries must be presented will all available care options so they can make a choice about what setting they prefer to receive their care in.
SEIU	9	17	LTSS Care Coordination: IHSS program structure under the demonstration	The California Department of Social Services (CDSS) must ensure that under the demonstration IHSS services are provided to all eligible recipients. Further, CDSS and the Department of Health Care Services (DHCS) must ensure that in implementing IHSS integration into the demonstration that all requirements of the Medicaid Act (Subchapter 19 (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code), the Americans with Disabilities Act (Chapter 126 (commencing with Section 12101) of Title 42 of the United States Code), Section 504 of the Rehabilitation Act of 1973 (Subchapter 5 (commencing with Section 794) of Chapter 16 of Title 29 of the United States Code), regulations implementing these federal laws, and all other applicable federal and State laws and regulations are met. These responsibilities should include but should not be limited to ensuring that provider payments satisfy the requirements of Section 1396a(a)(30)(A) of Chapter 7 of Title 42 of the United States Code.
SEIU	10	17	LTSS Care Coordination: IHSS program structure under the demonstration	County social services must always continue to perform their current IHSS functions, including assessment, authorization, and final determinations of IHSS hours in accordance with statutory provisions for IHSS eligibility, on behalf of the Medi-Cal manged cared health plans. At no point, during the demonstration or after it is completed, should Medi-Cal managed care health plans take over those functions from County social services.
SEIU	11	17	LTSS Care Coordination: IHSS program structure under the demonstration	It is important that heath plans have the ability to authorize additional home- and community- based services, including IHSS hours above the statutory limits, to ensure beneficiaries are able to remain safe, healthy and independent in their homes and communities. However, it is equally important that health plans be prohibited from covering fewer hours than those authorized by a county.
SEIU	12	17	LTSS Care Coordination: IHSS program structure under the demonstration	Outside of existing waiver services, all personal care and homecare services provided by the Medi-Cal managed care plans must be provided throught the IHSS program for those who are eligible.
SEIU	13	24	D. Stakeholder Engagement and Beneficiary Protections: Ongoing Stakeholder Feedback	The products and policy recommendations of the stakeholder workgroups organized by the State to support the development and implementation of the demonstration must be applied uniformly to each year of the demonstration as it extends into new service areas across the state.
SEIU	14	27	Beneficiary Protections: Appeals and Grievances	Regardless of what the final grievance and appeals process entails, existing IHSS rights must be maintained as in current federal and state law.
SEIU	15	28	Expected Outcomes: State's Ability to Monitor, Collect and Track Data on Quality and Cost	The state should establish a branch under the Managed Care Ombudsman specific to LTSS as managed care benefits. This branch should assist in monitoring and evaluating plan performance, assisting recipients with enrollment decisions , appealing denials and other plan decisions regarding service, as well as navigating other problems.
SEIU	16	29	Potential Improvement Targets for Performance Measures	Performance measures and improvement targets should be monitored and evaluated throughout the demonstration. In addition to those listed, potential improvement targets should also include the following: (1) Improved quality, adequacy, and impact of LTSS (2) Improved Health, functional, and health-care related outcomes (3) Improved family and unpaid caregiver outcomes (4) Improved paid personal assistance worker and workforce related outcomes
SEIU	17	30	F. Expected Outcomes: Expected Impact of Demonstration on Medicare and Medicaid Costs	There should be legislative informational hearings regarding the transition of Medi-Cal long-term supports and services (LTSS) into managed care at the end of each demonstration year. Further, continuation of the integration of Medi-Cal LTSS into managed care under the demonstration should be contingent on approval by the Legislature.
SEIU	18	30	Expected Impact of Demonstration on Medicare and Medicaid Costs	The State should invest the savings accrued as a result of the demonstration back into the Medi-Cal program, specifically Medi-Cal LTSS, in order to continue to promote better care and health outcomes for consumers, and to reduce costs for those who are dually elgible for Medicare and Medicaid, resulting in further savings in both programs.
SEIU	19	32	G. Infrastructure and Implementation: Six-Month Stable Enrollment Period	As previously stated in comment #2 regarding the Enrollment Process (p. 10), the six-month stable enrollment period unnecessarily curtails consumer choice and infringes on the protection that opting-out gives beneficiaries in deciding where and how they receive their care, and it should be eliminated from the demonstration proposal.
California Medical Association	1	4	"Local Stakeholder Process"	CMA would like to see standards regarding the required local stakeholder processes. At a minium, we believe the plans should be required to coordinate with the county medical societies and with physicians who have traditionally seen dual eligible patients. The California Medical Association and the County Medical Societies should serve as repositories of complaints and information.
California Medical Association	2	10	"Geographic Service Area"	As stated in the accompanying letter, CMA believes that DHCS should consider using smaller counties, or incuding only a portion of duals in the larger counties.

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California Medical Association	3	10	"Enrollment Process"	CMA reiterates our concern about the passive enrollment process. We would strongly prefer a patient "Opt-in."
California Medical Association	4	10	"Stable Enrollment Period"	Although some stable enrollment period is likely needed, DHCS should consider allowing a more flexilble process for auto-enrolled patients. Since these patients did not select their plan, they should be able to move sooner. Those patients should have the ability to change plans the first of the month after they intially contact the health plan for services.
California Medical Association	5	11	"Provider Networks"	Robust provider networks are absolutely crucial to the success of any demonstration project. To that end, CMA believes that the plans should be as accomodating as possible to community physicians who attempt to join their networks to be involved in the demonstration.
California Medical Association	6	11	"Provider Networks"	CMA also believes that plans should be required to include in their networks safety net physicians in all practice settings, including private small practice physicians and non-FQHC clinics. The plans should also be required to work with any physician who works with a large dual eligible population under the fee-for-service system.
California Medical Association	7	14	"Medical Homes"	CMA supports the concept of providing every dual eligible patient a medical home. However, we believe it is essential to clarify what services are intended to be included in that medical home. CMA recommends the "Joint Principles of the Patient Centered Medical Home" developed by the national primary care medical societies (AAP, ACP, AAFP, and AOA).
California Medical Association	7	15	"Use of Technology"	Although the proposal calls for expanded use of electronic health records, it could have the effect of undermining this goal. Under the Medicare EHR incentive program, each physician's incetive is based on 3/4 of their Medicare Part B charges. By moving patients from Medicare Part B into Part C (managed care), this plan could cost physicians thousands in incentive payments.
California Medical Association	8	18	"Evidence-based Practices"	Health plans should be required to: 1) cover all services currently covered by fee-for-service Medicare, and 2) consult with physicians, such as through physician advisory panels, to judge the clinical evidence base.
California Medical Association	9	26	"Network Adequacy and Care Continuity"	It must be very clear to the plans involved in the project that the definition of "safety net and traditional providers" includes private small practice physicians actively involved in treating dual eligibles today. Plans should also be required to contract with an adequate number of mandated providers at no less than Medicare rates.
California Medical Association	10	26	"Network Adequacy and Care Continuity"	CMA believes that the plans should, at a minimum, cover all services currently covered by the Medicare and Medi-Cal programs. CMA further believes that plan formularies should cover all drugs currently covered by Medicare. Finally, patients should be allowed to opt out or change plans if their plan changes covered servies or pharmaceutical formularies.
California Medical Association	11	26	"Network Adequacy and Care Continuity"	The "continuity of care " provisions should include specific protections for duals who have are in the middle of a course of treatment. The plans into which they enroll should be responsible for all treatments approved or deemed approved under Medicare or by another health plan which are still in progress.
California Medical Association	12	27	"applicable Medi-Cal fee-for-service rate"	CMA believes this may be a typo, and that DHCS actually intended to reference the "Medicare" fee-for-service rate. If not, CMA would ask DHCS to use the Medicare rate instead.
California Medical Association	13	28	"Financing and Payment"	CMA believes that the physicians should be able to freely negotiate reimbursement rates with plans, with the Medicare fee schedule as a "floor" for payment.
California Medical Association	14	28	"Financing and Payment"	The plans involved in the project should be required to update their systemsto comply with the most recent common procedure terminology (CPT) codes, modifiers, and correct coding initiative (CCI) edits. This is a problem in the current Medi-Cal managed care system, as different plans are on different coding systems. Fee-for-service Medi-Cal is also not current with Medicare. Medicare coding practices should apply for all dual eligibles.

Organization	Comment #	Page # of Proposal	Relevant Language	Proposal Draft Language & Comment